The Lighthouse Project: Focus Group Findings on Educating Parents and Supporters of Children with Mental Health Needs in Rural and Regional Settings.

Lighthouse Project Team.
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Background to the Lighthouse Project.

The lack of specialist services for those living in rural and regional Australia with mental health needs is widely acknowledged (1;2). This lack of specialist services is particularly pronounced for children in these regions (3). While mental health morbidity is not necessarily higher in regional and rural communities, the comparative lack of services misses the vital opportunity for early diagnosis and prevention interventions. These interventions can mitigate the impact of emergent mental health disorders. This is particularly so for pre and early pubescent populations entering the 12- 24 yar old age group where some 70% of mental health disorders emerge (4). This is not a challenge that is unique to Australia, with many other countries, both developed and developing, also struggling to meet childrens' mental health needs outside of metropolitan settings.

In a recent scoping review of recent international research four strategies for responding to these challenges were identified (5). Tele-health was utilized for two major approaches, training generalist staffs in mental health capabilities and supporting the provision of direct clinical services including both therapy and diagnostic services (6;7). Role shifting was also a frequently used strategy. Role shifting refers to the training of non-mental health clinician, teachers, parents or other supporters in undertaking mental health screening and therapy interventions for rural and regional children (8). Both tele-health and role shifting strategies had supporting research findings suggesting they can be effective in improving mental health service provision, where they are supported by community leaders, administrative systems and periodic input from mental health professionals (5). Co or proximal location of mental health services with schools was also a widely adopted strategy. This was particularly effective in reducing the travelling time associated with receiving mental health services in rural locations (9). Finally, the integration of rural and Indigenous cultural factors was essential for any of the other three strategies to be fully effective (10). These review findings were then presented to two regional consultation groups of child mental health clinicians (N=28) in early 2024. These clinicians confirmed that these strategies had resonance with their clinical experiences and would be effective aids if implemented. They we also accessed to commence the snowballing recruitment for the subsequent focus groups.

The findings of the scoping review were then considered in conjuncture with an earlier pilot project undertaken by Health Voyage (Headspace Coffs Harbour) and Southern Cross University. This pilot project called 'Parentspace', was a six-week education and parent capability development programme. Outcomes included enhanced supportive relationships, more frequent and effective parent-led conflict resolution, increased parental understanding of mental illness and parental-led strategies to mitigate the impacts of inter-generational trauma (11). Key mechanisms of success included content having relevance to stakeholders' needs and parents learning new capabilities to regulate their child's emotions, as well as their own.

Building on this pilot the current Lighthouse Project was developed. Key development stages have been digitalising components of the pilot resources, updating evidenced based content and engaging in a stakeholder consultations process to ensure programme content and design is tailored to need from end user perspectives. This consultation was through focus groups which allow for those with lived experience of the phenomena being explored to share in-depth expertise (12).

Aim of focus groups.

To refine the existing training content for digital delivery to parents and supporters of a younger cohort through eliciting lived experiences of:

- Rural and regional parents/supporters of children aged 10-13 perceived needs, service deficits and what education would better support them.

- Clinicians currently treating new entrants to services on what education and capability development would have potentially mitigated impacts of emergent mental health challenges; and,
- Rural and regional primary teachers, on their perceived needs within the context of their protracted contact with the 10-13 age group.

Method.

Ethics approval was sought and approved by the Southern Cross University HREC: Approval number 2024/057.

Recruitment was undertaken using a snowballing strategy of the professional networks from the two regional consultation groups of child mental health clinicians. Those with current lived experience of the investigative topic were sought. Grocery vouchers worth $50.00 were used as a recruitment strategy.

Ten parents/supporters participated in one focus group with ten teachers/clinicians attending a second focus group. Both focus groups were run by two experienced researchers and were video and audio recorded using Zoom technology. Both focus groups ran for 90 minutes. Eleven of the nineteen participants were male and nine identified as female. Five participants identified as an Indigenous Australian. Four were aged 20 -30 years; thirteen were aged 30- 40 years, two aged 40-50 years and one participant declined to respond. Eight were parents, two carers, four mental health clinicians and six were teachers, including one head teacher.

Sessions commenced with a brief presentation of findings from the recent scoping review on rural and regional services for children with mental health challenges (5), to then commence the group discussion on their experiences of the related issues. Both groups (N=20) were asked to critically discuss the proposed course content, any important considerations of how the training is presented and what rural, regional or remote factors needed to be considered in preparing and delivering the course.

Content analysis of findings was then undertaken with two researchers concurring on all retained findings.

Findings.

Protracted wait times and poor access to specialist services

Parents and carers experiences resonated with the findings from the recent scoping review. Protracted wait times for specialist childrens mental health services resulted in many having to travel long distances to metropolitan centres:

> (RP14 Parent) "*Getting appointment for my son is really hard. Staying in a rural area where they are no hospitals, traveling down to the city every month and he end ups being on the waiting list*".

> (RP15 Parent) "*It's been really tough 12 months here trying to get the supports he needs. No services available. Long waits are our biggest problem. I've been on a wait list for 9 months for a local paediatrician. He needs the paediatrician, a speech therapist and occupational therapist*".

Permanent moves to where services are located was considered, but such strategies were tempered by this also resulting in being distanced from supporting networks of family and friends.

Children's mental health needs were often complex with local workforce in both health and education being under skilled to effectively respond to these needs. Additionally, workforce capability for early diagnosis and intervention was also reported as lacking. Tele-health was not valued, being linked to poor diagnostic outcomes and parent voices not being heard:

> (RP15 Parent) "*We were having a lot of telehealth. They were trying to diagnose my son over telehealth. I said I would prefer to wait till you can actually see what's going on in person. And when we finally got to city, they are like 'you are 100% correct, what we were seeing via telehealth is a totally different thing in his day-to-day life*'.

The challenge on unmet need was also identified in the clinician and teacher focus group:

> (RP17 Head Teacher) "*I find the biggest unmet need is the whole family getting access to services in the area in rural areas. Then guiding them to know what to do and how to prioritize their needs, what's a serious risk, and what's not*"?

Acceptability of the proposed course content

The proposed course content was universally accepted as being valuable, with no important topics being identified as missing, by any of the participants. The following section summarises participants views on the six proposed core content areas in the program.

1. Family Based Education:

All stakeholder groups identified that emphasising the family as a mechanism for generating positive change was important content:

> (RP4 Teacher) "*So I feel like, if it's brought down to the family, that they have a part to play as well, not just the teachers, not just the clinicians, not just the occupational therapist and that it could create positive changes".*

> (RP13 Parent) *"Family based education enhances the mental health literacy of both parents and people around us with mental health conditions. It helps reduce the stigma, when people educated about mental health conditions, you know it helps reduce stigma".*

> (RP11 Clinician) "*I do agree with the family content. The child's first learning ground is the family or the home and the best thing would be to educate the parents or the carers on how to safely relate with the kids, how to understand*

emotions, the expressed and unexpressed emotions, as it would make them comfortable to speak up if they face any difficulties"

Key family issues participants identified as important content for the training course included:

- Emphasising families spending quality time together including sharing memories, photos and meals;
- Promoting open and honest communication to resolve conflicts and strengthen relationships;
- Educating children on understanding and de-stigmatizing mental health; and,
- Shared to-do lists: Allow family members to create and share to-do lists.

2. Physical education content:

The physical aspects of mental health, inclusive of causative explanations for young peoples' behaviours, and as well-being strategies was presented to both focus groups. This also attracted broad agreement from the stakeholder groups:

(RP 12 Carer) "*Yes. Including biological and neurological aspects in mental health discussions is essential for providing support*".

(RP14 Parent) "*Absolutely! Mental health is complex and understanding the biological factors will provide a comprehensive overview*".

(RP9 Teacher) "*I think understanding how the brain develops and functions can influence behaviours provides valuable insights for parents and teachers*".

Strategies for eating disorders and the importance of exercise attracted interest from multiple participants through the Zoom chat:

- Links between biological factors and mental illness needs to be highlighted.
- Biological factors to include in an education program included diet, exercise and sleep.
- Promote healthy lifestyle habits within the family, such as regular exercise.

Additionally, the importance of making the content accessible to different levels of education was highlighted:

(RP19 Teacher) "*I was just thinking about some of the barriers particularly in my school setting. It's a bit of a unique school setting. And I'm wondering about the complexity sent to parents. Will there be some visuals? For our parents that have lower literacy levels like a 1 pager sort of situation*".

3. Screen time education:

Strategies to reduce screen time was a prominent issue. This was linked to other content areas including family systems and physical wellbeing factors such as exercise:

(RP1 Parent) "*Everywhere you go phones, you come back to computers or televisions. Go out and just have a taste of nature. You can just go out to a quiet place under a tree, or some way have a taste of nature, and also social connections*".

All stakeholder groups identified screen time strategies as being important content for young people's mental health:

(RP15 Parent) "*Yes I agree that physical and mental health are connected. I try and get my son off his iPad and walking on the beach of the afternoon*".

(RP11 Teacher) "*Absolutely! A section on screen time and health is highly relevant, especially in today's digital age*".

Overt links to sleep, bullying, social confidence and meeting new people were made in the Zoom chat and promoting reduced (but not eliminated) screen time was also raised as being important:

> (RP19 Teacher) "*Yes this is very relevant, parents ask me about screen time all the time. As head of technology at the school I support limiting screen time but also there are many positives to technology*"
>
> (Clinician) "*Yes the screen time should be talked about, it would help the course*".

4. Anxious Child education:

Strategies for managing an anxious child was also confirmed as important content by all stakeholders:

> (RP13Parent) "*Including strategies to support anxious children, especially those with neurodiversity, is essential. These children face unique challenges, such as social anxiety*".

This wide agreement highlighted the unique needs of neurodiverse children particularly in the context of unmet needs:

> (RP12 Carer) "*Acknowledging and addressing the unique needs of neurodiverse children, we can help them thrive*".
>
> (RP17 Teacher). "*It can be really tough because anxious behaviours can play out in a lot of different ways and in the plethora of unmet mental health need its harder*".

Practical strategies were also identified and included physical and biological considerations. Highlighting strategies for social skills (especially for those who are neuro-diverse), creating safe environments and enhancing self-esteem and confidence were also identified by participants, along with simple yet effective aids.

> (RP16 Clinician) "*In the 10 to 13 year old space, they can be fun, you know. Using no- tech stuff, I have Rubik's cubes, and those 'bendy things' in my room, and fidget spinners; these are all helpful*".

5. Emotional Intelligence education:

Emotional intelligence, particularly skills in emotional regulation, were a theme throughout the focus group with particularly strong support from teacher participants:

> (RP9 Teacher) "*Absolutely, incorporating a section on emotional intelligence in this course would be really beneficial. It helps to understand emotions better and communicate effectively, all important skills*".

Emotional Intelligence capabilities were also identified as needing to focus on parental emotional literacy and as a self-care resource for teachers:

> (RP19 Teacher) "*Yeah. So just bouncing off others about the families from a cultural barrier perspective. What I'm seeing a lot of in our community is when you ask parent how they feel, and they'll say 'Good'. That's just their response. It'll be good whether it is or not, as then they don't have to express their feelings. That would be fantastic, the emotional intelligence If there was opening that vocab and teaching the parents different tools that they could use. Expecting them to help the children is really hard*".

(RP5 Teacher) "*Emotional intelligence is a vital skill for teachers, especially when working in rural areas where resources may be limited. Including a section on emotional intelligence could be incredibly valuable*".

Emotional regulation and emotional awareness were identified by other stakeholders as making an important addition to the course content:

(RP 7 Carer) "*Stronger emotional regulation: Anxious children often struggle with emotional regulation. Strategies to help children regulate their emotions, can empower them to respond to challenging situations*".

(RP16 Clinician) "*Something with children in that age group that I noticed is not really understanding how to express anger. You know safely, or, you know. We have to acknowledge as adults the power imbalance as well, it's more difficult for that child to be angry at the parent. I think parents should hear this*".

6. Risk Education:

Educative content on risk, especially early identification, early intervention and proactive steps was endorsed by all participants.

(RP3 Parent) "*I think it's crucial and very important to identify risk and signs of various mental health, you know. Educating parents, caregivers and children on warning signs or symptoms".*

(RP15 Parent) "*Yes absolutely it needs to be included in the program*".

(RP18 Carer) "eating disorders, anorexia, bulimia, they can have severe health consequences if left untreated".

Teacher participants highlighted the Departmental support that schools receive for managing risks, but that it remains a challenging undertaking:

(RP17 Teacher) "*In the Department of education. We're supported to write pretty comprehensive risk assessments. A directorate looks over our risk assessments and advise us to draft up particular strategies at a school level. Often, we're looking at responding through de-escalation strategies to risky behaviours and it can be really tricky. It's a really tricky space to work with kids*".

Conclusion.

The Lighthouse Project seeks to add mental health capabilities and knowledge for rural and regional parents/supporters of children aged 10-13 with mental health needs. The relative paucity of specialist services in relation to that need was evident in the recent scoping review (5), and was confirmed by participants in these focus groups.

Proposed course content for the Lighthouse Project was drawn from a pilot that showed some evidence of being helpful to parents and carers of an older cohort of young people (11). Data from these focus groups confirmed multi-stakeholder agreement that the six content areas were relevant for those caring for 10–13-year-olds. Additionally, participants did not identify any content gaps, despite being encouraged to do so.

The proposed course content also offers useful areas for clinicians and other service providers to prioritize when offering psychoeducation to parents/supporters of children aged 10-13 with mental health needs in rural and regional settings.

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