Piloting a parenting skills program in an Australian rural child protection setting

Rosemaria Flaherty and Rodney Cooper

This rural pilot study examined the effectiveness of a brief parenting skills intervention delivered to parents/carers of children who had experienced moderate to severe child abuse. The participants were 35 parents/carers living in rural New South Wales, Australia, who were recruited through referrals to a rural community health service. Participants were assessed pre and post the brief parenting skills education program using a battery of standardised self-report measures. Participants were randomly assigned to an immediate intervention group or a 3-month waitlist control group. The intervention was a three session '1-2-3 Magic' parenting program.

T-test analyses indicated that carers who received the intervention reported significant improvements in their mental health and discipline practices, and a significant reduction in child problem behaviour compared to the waitlist control group.

The results of the study suggest that a brief psycho-educational parenting group intervention may be effective for carers of abused children in the short-term.

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The experience of child abuse can detrimentally affect a child's behaviour in many ways. Consequently, parenting interventions are often required for managing multiple and complex behaviour problems in abused children (usually externalising disorders), including the lack of ability to self-regulate emotion and dysfunctional, or delayed, development of social skills (Sawyer et al. 2000).

Parents and carers report that one of the biggest stressors of the parenting role is 'managing behaviour' (Kazdin, Bass, Ayers & Rodgers 1990). However, very few government agencies, such as public community health centres, offer parenting courses. Courses provided by some non-government agencies vary greatly in their capacity to maintain standardised program content and retain consistent staffing levels to successfully deliver programs.

In the Australian context, a national literature review undertaken recently by Tully (2007), which focussed on early intervention strategies specifically for children and young people aged 8 to 14 years, showed there are three universal parenting programs that have been assessed for use with this age group in Australia. These programs are *Triple P-Positive Parenting Program* (Sanders, Cann & Markie-Dadds 2003), *Parenting Adolescents: A Creative Experience* (Toumbourou & Gregg 2002), and *Parenting Between Cultures* (Kayrooz & Blunt 2000). A less well recognised parenting program for carers of children aged 2-12 years is *1-2-3 Magic* (Hawton & Martin 2006). The aim of the *1-2-3 Magic* program is to educate carers to better manage unwanted behaviour, encourage wanted behaviour and strengthen the relationship between parent and child A signalling system of non-coercive warnings via a simple counting system is the main technique taught. *1-2-3 Magic* has been validated by Bradley et al. (2003) in a Canadian study, using 222 participants who were primary caregivers and who attended 3 weekly group sessions followed by a one-month booster session. The authors found carers reported significant improvements in parenting practices and a reduction in the reporting of problematic behaviour in their children. However, in relation to evaluation of these programs for parents and carers in the child protection context, there is a scarcity of literature about the effectiveness and outcomes of parenting programs (Portwood 2006).

The *Child Protection Australia 2007-2008* report (AIHW 2009) records that 103,355 children in the state of New South Wales alone were the subject of a report of being at suspected risk of harm. Anecdotally, public health centres have high referral rates of abused children and young people, with under-resourced rural services in particular feeling the strain. In an analysis of published studies of psychotherapy referrals, Kazdin et al. (1990) reported that disruptive child behaviours – such as 'acting out' and 'behaviour problems at home' – were the most common difficulties for which parents/carers sought professional advice. While parenting programs such as the *Triple P-Positive Parenting Program* may be suitable for use within well-resourced clinical units, rural area implementation poses special challenges for healthcare providers. Overcoming the tyranny of distance perpetuated by isolated 'village' geographical locations, getting rural residents without private transport to groups, and ongoing budgetary constraints and staff shortages in rural health services are challenges which impact on program delivery. Marginalised families often need intensive support to get to parenting programs and to stay involved for the duration. Usually this is because of the extreme stressors they are facing – financial issues, homelessness, family violence and geographical isolation. A study by Sanders et al. (2000) found that families with the highest level of reported child behaviour problems, marital conflict and depression were the most likely to drop out and not complete a parenting program.

Furthermore, when considering these complex factors, rural health service managers need to be confident that the implementation of a group parenting program will deliver reasonable outcomes, but will not further strain limited staffing resources. In both general parenting programs and parent training programs targeting the prevention of child abuse, concerns about the efficient use of limited resources are widespread (Lundahl, Nimer & Parsons 2006; Lundahl, Risser & Lovejoy 2006). The results of one study, specifically focused on improving the attachment between mother and infant, indicated that providing both parent psychotherapy and a psycho-educational parenting intervention could successfully alter the insecure attachment patterns of infants in maltreating families (Cicchette, Rogosch & Toth 2006). The authors concluded the intervention had been successful by measuring and comparing the pre and post intervention functioning of the mother-infant dyads, with mothers and maltreated infants receiving support only through the Child Protective Service.

However, retaining parents in such a program over a long period of time can be very challenging and resource intensive. Often the literacy levels of those parents being targeted are over-estimated, and perhaps programs need to realistically aim at retaining participants voluntarily for 3 sessions as a first step. Many commonly used parenting programs in Australia are of much longer duration; for example, *Triple P-Positive Parenting Program* Level 4 upward – eight to ten sessions, *Parent Child Interaction Therapy* – 10-20 sessions, *Incredible Years* – 12-14 weeks (Tully 2009). The number of sessions required to complete the course may be a contributing factor in participants dropping out prior to completion. Markie-Dadds and Sanders (2006) conceded that factors such as full-time employment, shiftwork, inadequate child care or transport, financial difficulties and geographical isolation all contribute to parents' inability to attend clinic-based parenting sessions for the duration of the full parenting course.

THE STUDY

Whilst child abuse does not discriminate across culture, socioeconomic status, religion or race, there are regular correlations in the literature with contextual risk factors such as poverty, parental substance abuse, crime, mental illness and life stressors (Commonwealth of Australia 2004; Sidebotham & Heron 2006). The rural area in which this study took place is an identified area of concentration of disadvantage according to postcode area in New South Wales (Vinson 2004). Characteristic features of the area include elevated rates of long-term unemployment, low income, early school leaving, unskilled workers, low birth weight, substantiated child abuse, psychiatric hospital admission, criminal offence convictions, serious child injuries, imprisonment, mortality, and financial reliance on disability support pension or sickness benefits.

This pilot study aimed to examine the effectiveness of *1-2-3 Magic* as a brief parenting skills intervention delivered to parents and carers of abused children living in a rural area. *1-2-3 Magic* is a parenting program which supports parents and carers to learn how to manage difficult child behaviour and praise positive behaviour. It is a commercially available product developed in 1984 by Dr Thomas Phelan. The program can be run with individual parents or carers or in a group format. The program duration is three sessions and parents are taught simple strategies to assist with controlling unwanted behaviour, encouraging good behaviour and strengthening their relationship with their child (Phelan 2003). It was hypothesised that a 3 session, didactic *1-2-3 Magic* parenting program intervention would significantly increase levels of self-reported parenting satisfaction and reduce levels of self-reported anxiety, depression, stress and dysfunctional parenting style in referred parents and carers of abused children.

METHOD

Participants

The participants were 35 parents or carers of 99 children who had been the subject of child abuse and neglect reports, some of which had been substantiated. The mean age of

Table 1: Self report assessments used to measure caregiver perceived skills pre and post *1-2-3 Magic* intervention

Name	Authors	Description	What is measured?	Score interpretation
Depresssion, Anxiety, Stress Scale (DASS)	Lovibond & Lovibond, 1995a	42-item questionnaire measuring depression, anxiety, stress	Parental/carer emotional state	Higher scores indicate more severe depression, anxiety, stress
Eyberg Child Behaviour Inventory (ECBI)	Eyberg & Pincus, 1999	36-item rating scale of intensity of child behaviour and how much of a problem the behaviour is	Disruptive behaviour in children	Higher scores indicate more intense behaviour and problematic behaviour
Parenting Scale (PS)	Arnold, O'Leary, Wolff & Acker, 1993	30-item questionnaire where parents describe three dysfunctional parenting styles: Laxness, Over reactivity & Verbosity	Main outcome measure of parent/carer behaviour change	Higher total scores indicate higher levels of anger, meanness, irritability, failing to enforce rules, arguing
Parenting Satisfaction Scale	Guidubaldi & Cleminshaw, 1994	45-item self report rating overall degree of parenting satisfaction	Satisfaction with the parenting role	Higher scores indicate higher satisfaction with parenting role and parent-child relationship

carers for the groups was 43 years for the 'intervention' group, and 36 years for the 'waitlist' control group. All participants were English speaking, and were the primary carer of a child aged between 2 and 16 years, having been recruited through child protection referrals made to the Department of Community Services (DoCS), and other regional agencies (Sexual Assault Service, Child and Family Counselling, Women's Refuge and Pharmacotherapy clinic). Referrals were broadly representative of the child protection-related referrals commonly seen by Physical Abuse and Neglect of Children (PANOC) counselling services. Originally, 55 individuals were referred, with 38 participants successfully recruited for this pilot study. Unfortunately, 3 participants dropped out of the study and were unable to be located to ascertain the reason for dropping out.

No known child interventions were occurring while the program was being conducted, apart from case management by the statutory child protection agency (DoCS), which was the process in place to ensure the children's safety and welfare. DoCS caseworkers conducted the assessments that determined whether a parenting course was the best option to address some of the identified problems for the families who were subsequently referred to the program.

Type of abuse

Seventy-seven per cent of families indicated the children in their care had suffered multi-abuse types. Of the 35 families, 32 reported a child or children in their care had suffered emotional and psychological abuse. Twenty-five families reported the child in their care had been exposed to domestic violence. Fourteen families identified the child had been neglected, while 11 families reported known physical abuse and 8 families reported known sexual abuse histories.

Measures

A battery assessment approach to data collection was employed to enable comparison with other parenting research. The standardised assessments used are listed in Table 1.

Procedure

The research protocol was approved by the North Coast Area Health Service Human Research Ethics Committee. The inclusion criteria for the study was parents or carers of children subject to child abuse or neglect that had been substantiated, including children living with birth parents and out-of-home carers, whether that be foster care or kinship care; and parents or carers of 'at-risk' children who had reported marked parenting stress. Participants were randomly assigned to either an immediate 'intervention' group or a three-month 'waitlist' control group. The pre-test battery of questionnaires was administered to both groups. The intervention group attended three sessions of the *1-2-3 Magic* program, which was delivered using the standardised training manual instructions and program DVD. Post-test measures were completed after the intervention was concluded. *1-2-3 Magic* was offered and provided to the waitlist control group after post-test measures were collected.

Statistical analysis

T-test analyses were used to compare the two groups on a number of main variables at referral, or pre-test, and after 3 months (post experimental in the intervention group, and prior to the intervention in the waitlist control group). The intervention and waitlist control groups were not matched. There were differences in sex, identification as Aboriginal and/or Torres Strait Islander descent, and education. However, there was no significant difference between employment and marital status.

RESULTS

Outcome measures

Depression, Anxiety, Stress Scale (DASS) scores were significant on all three variables. Scores are weighted according to the severity of the symptoms reported. Depression scores above 13 are labelled as moderate depression, Anxiety scores above 9 are considered moderate,

Figure 1: Mean 'pre' and 'post' scores for parent/carer depression, anxiety and stress scores in intervention group

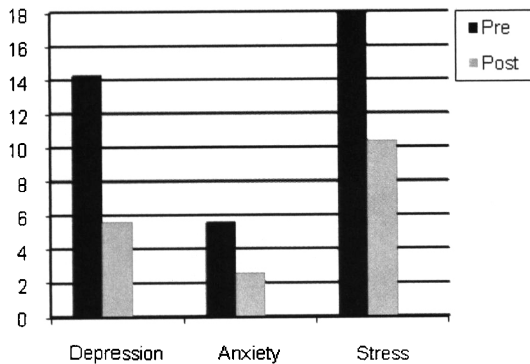
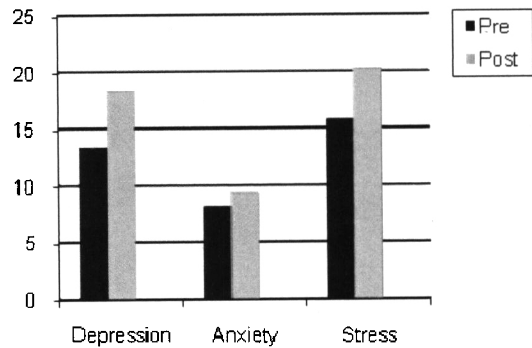


Figure 2: Mean 'pre' and 'post' scores for parent/carer depression, anxiety and stress scores in waitlist control group



and Stress scores above 18 are also moderate. Figure 1 shows the 'pre' and 'post' changes in the DASS scores for the intervention group. Mean raw scores (p <0.01) of Depression reduced from moderate at 14.3 (Std. Error 2.4) to normal at 5.6 (1.2), Anxiety reduced from 5.6 (1.3) to 2.6 (0.7), and Stress reduced from moderate at 18.0 (2.7) to normal at 10.4 (1.4). Parent/carer severity ratings, as a group, changed pre to post intervention from moderate to normal for Depression, remained normal for Anxiety, and reduced from moderate to normal for Stress.

Figure 2 shows the pre and post changes in the scores for the waitlist control group. Mean raw scores (p <0.01) of Depression increased from 13.3 (Std. Error 2.6) to 18.4 (2.8), Anxiety increased from 8.1 (1.6) to 9.4 (2.4), and Stress increased from mild at 15.8 (2.3) to moderate at 20.3 (3.1). Parent/carer severity ratings as a group changed pre to post control, moving from the lower to upper limit of moderate for Depression, moving from the lower to upper limit of mild for Anxiety, and increasing from mild to moderate for Stress.

Table 2: 'Pre' and 'post' intervention and waitlist control group mean scores on the Eyberg Child Behaviour Inventory (ECBI)

ECBI score	Pre		Post	
	Mean	(SError)	Mean	(SError)
INTERVENTION GROUP				
Intensity (clinically significant cut off score 131-133)	165.1	(9.8)	144.2	(9.0)
Problem (clinically significant cut off score 15)	23.2	(1.4)	15.6	(1.6)
WAITLIST CONTROL GROUP				
Intensity (clinically significant cut off score 131-133)	147.9	(12.8)	152.3	(10.9)
Problem (clinically significant cut off score 15)	19.4	(2.1)	20.1	(1.8)

The mean pre-test and post-test Eyberg Child Behaviour Inventory (ECBI) scores for both the intervention and waitlist control groups are presented in Table 2. The analyses of change in pre to post ECBI scores for carers were performed using paired t-test (2 sided) using Intensity and Problem as the two variables of interest. A significant difference was found (p<0.01) for Intensity and for Problem T-scores. Intensity cut-off scores are at 131-133 and Problem cut-off scores at 15. Intervention group scores for Intensity exceeded the cut-off on both pre and post intervention questionnaires. Intervention group scores for Problem exceeded the cut-off pre intervention and were exceeded by only 0.6 post intervention. Waitlist control group scores for both Intensity and Problem exceeded the cut-off for both pre and post intervention whilst waiting on the waitlist.

Parenting Scale (PS) scores are considered at a clinical level if the Lax Factor score is higher than 2.8, the Over-reactivity Factor is higher than 3.0, and the Verbosity Factor is higher than 3.4 (Arnold, O'Leary, Wolff & Acker 1993). The mean pre and post test PS scores for both the intervention and waitlist control groups are presented in Table 3. Intervention group scores show that the clinical cut-off was exceeded on both the pre-test Over-reactivity Factor and Verbosity Factor scores. However, all Factors reduced post intervention. Waitlist control group scores showed that the clinical cut-off was exceeded on the pre measure on all three factors. All Factors were considerably exceeded post waitlist.

Parenting Satisfaction Scale scores are given a percentile rank based on the level of overall satisfaction. The higher the percentile, the more satisfied the parent/carer is with aspects of their carer role. A significant difference was found at p<0.01 for the total Parenting Satisfaction in the intervention group. Pre parenting satisfaction increased from pre = 114.9 (3.4), a percentile rank of 20%, to post = 126.2 (2.9), a percentile rank of 42%, whereas the waitlist control group scored a total pre parenting satisfaction of 112.3 (4.4), a percentile rank of 16%, and post parenting satisfaction

decreased to 101.1 (5.8), a percentile rank of 6% satisfaction.

Discussion

The hypothesis that a three-session, didactic *1-2-3 Magic* parenting program intervention would significantly increase levels of self-reported parenting satisfaction and reduce levels of self-reported anxiety, depression, stress and dysfunctional parenting style in parents or carers of children who have experienced abuse was supported.

Self-reported DASS results, however, suggest that the participants in the intervention group had higher levels of depression, anxiety and stress before the intervention than the waitlist control group. Conversely, the participants' stress levels in the waitlist group increased as they waited for the intervention. This result could be explained by an 'intent to treat' factor, which is the effect resulting from the parents/carers feeling they have asked for help with an expectation of receiving it, only to find they have to wait to receive assistance.

Intervention group scores for the ECBI 'Intensity' of the child's behaviour exceeded the cut-off on both pre and post test questionnaires. Post test intervention ECBI scores were still well above clinical cut-off. Therefore, the statistically significant reduction is not necessarily a clinically significant one. This may mean that the abused children's behaviour will likely result in high scores on this measure – regardless of the intervention offered – due to the abuse they have endured.

Intervention group scores (ECBI) for the amount of 'Problem' behaviours a child exhibited also exceeded the cut-off pre intervention. However, these scores reduced post intervention to exceed the cut-off by only 0.6. This result indicates some support for Sanders et al. (1999) who observed that the fewer number of 'problem' behaviours that are reported, the more confident parents become in dealing successfully with the difficult child behaviours presented. Carers perceived their children as having fewer behaviour problems post intervention even though the behaviours still exceeded clinical cut-off for intensity.

Parenting Scale pre-group scores were similar for both groups. Parenting Scale scores were the measure of parental behaviour change in this study. As the study was a small pilot, it is possible that the educational nature of the program, coupled with small group participant numbers, resulted in the intervention group experiencing a bigger impact in the short-term. However, results may also be due to the provision of targeted support as parents talked about the importance of knowing about child development and how that knowledge positively changed their behaviour.

The level of Parenting Satisfaction more than doubled in the intervention group from 20% prior to intervention to 42% post intervention. The levels of parenting satisfaction, as gauged by percentile rank, were surprising. Both groups were very similar in their reported pre parenting satisfaction levels; however, the waitlist group showed a marked decrease in satisfaction and a marked increase in stress and dysfunctional parenting style as they waited for intervention.

Scores on all clinical measures were significantly high on the questionnaires prior to the intervention. The waitlist control group deteriorated over the 3 months, and perhaps this shows that when families are referred by agencies, they require a timely response. At the point of referral may be the best time to help, rather than referring already stressed families to a waiting list. Also, families may grow resistant to intervention over time if not helped early. Unfortunately, waitlists are standard practice for many under-resourced therapeutic services in rural areas.

Clearly, parents/carers were a disparate group with different coping strategies and different resources. Both groups reported similar levels of carer stress and child behaviour problems. However, the intervention group did show an increase in parenting satisfaction and a reduction in depression, anxiety, stress and unwanted child behaviour. The mean participant age of 43 years is well above the median parent age in Australia which, in 2008, was 30.7 years for mothers and 33.1 years for fathers (Australian Bureau of Statistics 2008). The question remains whether this type of program is being offered early enough for much younger parents than the mean participant age of 43 years in the intervention group.

Retention of participants in parenting groups is difficult – particularly when the program is run over a number of weeks (Markie-Dadds & Sanders 2006). This study shows that carers can indeed be retained over the three sessions of a brief intervention parenting program. This suggests that parents/carers of this high risk group of children can be recruited and retained, and that some sort of intervention makes a

Table 3: 'Pre' and 'post' intervention and waitlist control group mean scores on the Parenting Scale (PS)

PS score	Pre		Post		T-test
	Mean	(SError)	Mean	(SError)	(2 sided)
INTERVENTION GROUP					
Factor Lax	2.6	(0.2)	1.8	(0.2)	p=0.02
Factor Over-react	3.3	(0.2)	2.2	(0.1)	p<0.01
Factor Verbose	3.7	(0.3)	2.2	(0.2)	p<0.01
WAITLIST CONTROL GROUP					
Factor Lax	3.1	(0.3)	3.7	(0.5)	p=0.02
Factor Over-react	3.9	(0.3)	4.2	(0.3)	p<0.01
Factor Verbose	4.0	(0.3)	5	(0.2)	p<0.01

difference to the experience and confidence in their parenting role. The fact that carers were motivated to complete the program has implications for service configuration. High numbers of families are referred for service by DoCS and those services need to be better able to meet that need. Therefore, the *1-2-3 Magic* parenting program could be used, at minimum, as an educational tool with these families.

Limitations

These results are constrained by several limitations. Whilst this pilot study was applied research, it was limited by the realities of participant recruitment and a small sample size. Due to resource issues in the Community Health Service and the size of the scholarship fund, the first author fulfilled the roles of assessor and program facilitator. However, program fidelity was maintained by the materials (visual slides, *1-2-3 Magic* parenting program book, DVD and session outlines) being standardised. Another weakness of study design is that the questionnaires employed are self-report and participants may have reported positive results due to 'getting together', rather than from the educational content. Whilst the group was intended as an educational rather than a therapeutic group, the supportive nature of the group may have caused participants to feel more confident in their parenting role as time progressed.

Social desirability also may have inflated the positive results in that the intervention group knew their parenting was expected to improve as a result of participation in the program. In addition to this, the intervention group may have been anticipating an intervention, thus inflating the true changes attributable to the actual program.

CONCLUSION

Parenting issues are one of the most common reasons for referrals to Community Health Services, yet parenting groups are not routinely offered by government agencies. This study provides some evidence to suggest that the *1-2-3 Magic* parenting program may be a beneficial brief intervention to offer parents and carers of abused children. Some carers, whether parents or foster carers, readily report using coercive parenting styles, especially when stressed with this already vulnerable population of children.

This research provides some Australian data for *1-2-3 Magic*, and data collected in a rural context. In NSW rural locations, the challenges to service provision include: sole clinicians trying to deliver a service in an equitable manner; increases in child protection reports; and increases in DoCS referrals (sole referral source to PANOC services). The combination of these factors often results in a sole clinician not having the capacity to see every at-risk family straight away and increased risk of clinician burn-out. Therefore, services need to distinguish between primary and secondary intervention. The *1-2-3 Magic* parenting program can be considered a secondary intervention which has some potential to prevent further abuse. The efficacy of this program as a secondary treatment intervention, however, needs longitudinal research to track the maintenance of any improvements in parenting skills and confidence over time. ■

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