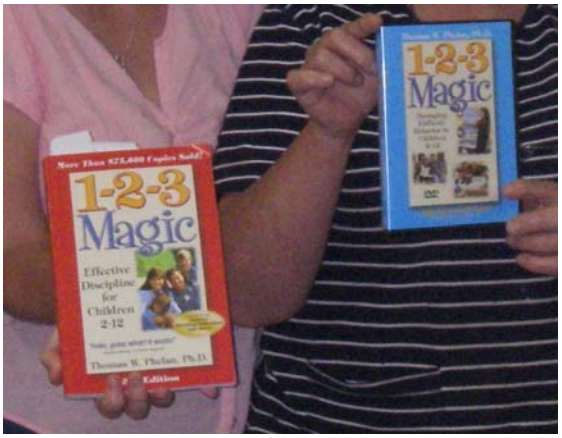


Trialling a 1-2-3 Magic Parenting Program in a rural Australian Child Protection setting

FINAL REPORT

Rosemaria Flaherty,
June, 2008

Research funded by:

NSW Institute of Rural Clinical Services and Teaching
NSW HEALTH

CONTENTS

Acknowledgements
Abbreviations

Research funded by

Acknowledgements

- The parents and carers that participated in the research
- NSW Institute of Rural Clinical Services and Teaching
- North Coast Area Health Service – Grafton Community Health Service
- Rod Cooper (University of Newcastle) – Associate Researcher & Mentor
- Sandra Begg – Family support worker
- Clive Gaskin – Biostatician (NSW Institute of Cancer Care)

Abbreviations

- DoCS -Department of Community Services
- NCAHS -North Coast Area Health Service
- NSWIRCST -NSW Institute of Rural Clinical Services & Teaching
- PANOC -Physical Abuse and Neglect of Children

Author

Rosemaria Flaherty, Physical Abuse and Neglect of Children (PANOC) Psychologist, Grafton Community Health Centre, NSW.

Other supporters:

NORTH COAST AREA HEALTH SERVICE NSW HEALTH & THE UNIVERSITY OF NEWCASTLE AUSTRALIA

1. EXECUTIVE SUMMARY:

The *1-2-3 Magic Parenting Program* (*1-2-3 Magic*) research project was funded by the New South Wales Institute for Rural Clinical Services and Teaching (NSWIRCST) scholarship funds. The project commenced in September, 2006 and was finalised in March, 2008. The active research phase was from mid July, 2007 to mid October, 2007.

1-2-3 Magic is a simple parenting program that suggests ways to better manage mis-behaviour in children from 3-12 years of age.
1-2-3 Magic aims to:

1. Control unwanted/undesirable behaviour (STOP behaviour)
2. Encourage wanted/desirable behaviour (START behaviour) and,
3. Strengthen the child-parent relationship (bond between parent and child) (Hawton & Martin, 2006).

The results of a large Canadian research study (Bradley et. al., 2003) showed that parents in the treatment group (compared to control group parents) were less stressed, less depressed and less angry after undertaking the program. The difference was sizeable as well as statistically significant (p=0.001). A second result showed that children's behaviour had improved significantly three months later indicating sustained impact of the program.

The main issue is that there is no Australian research data replicating these results.

This funded research pilot project explored the effectiveness of *1-2-3 Magic* specifically for use within the Physical Abuse and Neglect of Children (PANOC) counselling service in the Coffs/Clarence Network of the North Coast Area Health Service (NCAHS). Several other parenting programs such as Triple P-Positive Parenting, Parent Effectiveness Training and P5 programs, while commonly used, do not appear to be suitable to use with the population of parents/carers that have abused/neglected children, and who have complex problems coupled with low-socio-economic status and other social issues.

The research study utilised a pre-post design with a wait-list control group. The research tools were four standardised psychological assessment questionnaires used for pre and post testing and the 3-session *1-2-3 Magic* intervention program. Participants were 38 parents/carers who commenced the program with 35 carers (providing care for a total of 99 children) completing the project.

The particular research question to be answered was: Does the *1-2-3 Magic* program result in carers reporting they are less stressed, less depressed, less angry and more satisfied with their parenting role, when applied to a rural PANOC clinical population? Preliminary results suggest that this intervention was effective with significant differences between the intervention and control group obtained on all the test measures.

2. PROJECT RATIONALE:

What is the 1-2-3 Magic Parenting Program?

The *1-2-3 Magic Parenting Program* is an evidenced based, brief psycho-educational parenting program developed in 1984 by Dr Tom Phelan and validated in Canada (Bradley et al., 2003). Participants in the Canadian study were 222 primary caregivers. The caregivers attended 3 weekly group sessions of the *1-2-3 Magic Parenting Program* followed by a 1-month booster session. The authors found carers reported a significant improvement in parenting practices and reduction in the reporting of 'problematic' behaviour in their children. These improvements were maintained at one year follow-up in a subset of the experimental group.

The *1-2-3 Magic Parenting* 'program' consists of standardised visual slides for the 3 intervention sessions and an educational DVD that is shown to parents/carers. There are also published books, '*1-2-3 Magic'* and *'More 1-2-3 Magic',* that outline the program. A signalling system for warnings about behaviour is the main technique used in the program. Warnings are signalled via a simple counting system and the techniques provided in the program, to encourage wanted behaviour, are straight forward and non-coercive.

Evidence base for action

Parents/carers report one of the biggest stressors of the parenting role is "managing behaviour". However, very few government agencies offer parenting courses. Courses provided by some non government agencies vary greatly in relation to maintaining standardised program content and retaining consistent staffing levels to successfully deliver the program.

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

Currently, a number of 'parenting programs' have been developed and researched. There is a large body of literature that looks at the effectiveness of parenting programs especially for the treatment of conduct behaviour disorder and oppositional behaviour in children (Brestan & Eyberg, 1998; Serketich & Dumas, 1996). In a recent meta-analysis of the use of parent training to moderate disruptive child behaviour, Lundahl, Risser and Lovejoy (2006) found small to

moderate changes in child behaviour immediately following treatment. A total of 63 peer-reviewed studies were evaluated in the area of both behavioural and non-behavioural parent training interventions. The authors assert that the effectiveness of parent training is based on both the parent/carer characteristics and the content of the training program itself. Approaches include: Behaviour Parent Training (BPT), Intensive Family Preservation Services; Homebuilders; Parent-Child Interaction Therapy; Multisystemic Therapy; Parent Management Training; The Incredible Years Program; and, Triple P-Positive Parenting Program.

A review of 24 evidence-based treatment protocols for child abuse and neglect, including parenting programs, was conducted by the US Office for Victims of Crime in 2001. The results of the review of evidence based practice was summarised in an article by Chaffin and Friedrich (2004). The authors noted that there was mostly inadequate randomised trial evidence for Intensive Family Preservation Services and Homebuilders models whereas, results for Parent-Child Interaction Therapy and Multisystemic Therapy were promising. In addition to these programs, Kazdin (2005) found supportive evidence for Parent Management Training, the Incredible Years Program and Triple P-Positive Parenting Program in the prevention of child abuse.

However, Sanders, Pidgeon, Gravestock, Connors, Brown et al., (2004), in a study looking at parental attribution retraining and anger management using Triple P-Positive Parenting Program with parents at risk of child maltreatment, found the program a useful preventative strategy but did not use a control comparison group, and cautioned the application of the results to the child maltreatment population. Triple P-Positive Parenting Program (Sanders et al., 2004) and The Incredible Years Program (Hughes & Gottlieb, 2004) have had some alteration to implement with families where child abuse has been substantiated, however, still the retention rate of carers in these programs remains an issue.

A more recent review of American programs for parents of infants and toddlers, used evidence from randomised trials and concluded that

interventions would be improved it they were tested with different populations living in different contexts (Olds, Sadler and Kitzman, 2007). The authors noted that many interventions do not succeed in reaching and involving the target population. The current pilot study aimed to address that gap. Many programs have failed to recruit and retain parents and in Olds et al.'s review, Triple P-Positive Parenting Program and The Incredible Years Program (Webster-Stratton, Reid and Hammond, 2004) were excluded as there were no trials evaluating these programs for the under 3 years of age group (Olds, Sadler and Kitzman, 2007).

In the local Australian context, a recent literature review focusing on national early intervention strategies specifically for children and young people aged 8 to 14 years (Tully, 2007) showed that 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; Parenting Adolescents: A Creative Experience; and, Parenting Between Cultures. The author reviewed scientific literature published over a 16 year period from 1990-2006 and concluded that there is evidence for the effectiveness of Parent-Child Interactive Therapy (Chaffin, Silovsky, Funderbunk et al., 2004). This program involves parents being coached in managing the behaviour situation with their child using an electronic transmitter and receiver device. Parent-Child Interactive Therapy program extends for a duration of between 12 and 20 weeks.

In relation to evaluation of the programs for parents and carers in the child protection context though, there is a dearth of literature about the outcomes of these programs (Portwood, 2006).

Results of the above research studies have shown that negative parenting styles/approaches to behaviour management, increase the potential for child abuse. The *Child Protection Australia 2006-2007* report records 99,949 children in the state of New South Wales alone were the subject of a report of being at suspected risk of harm (Australian Institute of Health and Welfare, 2008).

The Triple P Parenting Program may be suitable for use within well-resourced clinical units, however public health settings have added challenges impacting on program delivery such as staff shortages, budgetary constraints, and high referral rates. Families with complex problems and low socioeconomic status who are marginalised need intensive support to get to parenting programs, and to stay involved in the program. Usually this is because of the additional extreme stressors they are facing in other aspects of their life such as financial issues, being homeless, dealing with family violence, and lack of transport options to attend programs.

Rural area implementation of parenting programs pose special challenges for healthcare providers of getting people to groups who don't have private transport, overcoming the tyranny of distance perpetuated by isolated geographical locations, and the current study population is highly mobile and has complex problems. As Sanders et al., (2000) found with their study, families with the highest level of reported "child behaviour problems, marital conflict and depression" were the most likely to drop out of the research and not complete the parenting program.

The current study aims to blend the *1-2-3 Magic Parenting Program* approach with the identified challenges that rural program delivery involves. Often target group literacy levels are overestimated and programs need to realistically aim at retaining participants for 3 sessions not the usual 12 sessions recommended by other parenting programs. Child abuse happens across societies and cultures, but can be magnified in regional areas due to a lack of accessible resources and support networks. 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. The rural area in which this study took place is an identified area of concentration of disadvantage according to postcode area in NSW (Vinson, 2004). Characteristic features of the area include elevated rates of: long term unemployment, low income, early school leaving, non completion of Year 12 schooling, unskilled workers, low

birth weight, confirmed cases of child abuse, psychiatric hospital admission, criminal offence convictions, serious child injuries, imprisonment, mortality and, financial reliance on disability, support pension or sickness benefits. Effective parenting programs require targeted recruitment which this study specifically attempted (Holzer, Bromfield & Richardson, 2006).

This study has therefore aimed to contribute to the building of an evidence base for the *1-2-3 Magic Parenting Program* in Australia within the public health system, specifically in rural Community Health. This research provides the first published Australian data for this particular intervention, and the first data in a rural context. In 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 Department of Community Services staffing (sole referral source). These factors combined often result in a sole clinician not having the capacity to see every at-risk family straight away and increased risks of burn-out. Therefore services need to distinguish between primary and secondary intervention. The *1-2-3 Magic Parenting Program* can be considered to be a secondary program which has potential to prevent further abuse.

3. LOCALITY SERVICED:

This research was undertaken in the Clarence Valley, which is situated in the Coffs/Clarence Network of the NCAHS. Two main Community Health Centres are serviced by the Northern part of the Coffs/Clarence Network and they are Grafton and Maclean. The total population of the Clarence Valley area is 50,143 (Australian Bureau of Statistics, Estimated Resident Population, 2007). The geographical catchment of this area covers an area of 11,049 square kilometres.

As can be seen from these figures, there is quite an expanse of area to be covered for a sole rural clinician attempting to provide an accessible and equitable service to residents of the catchment area.

4. PROJECT OBJECTIVES:

Project objectives included to:

- Determine the relative effectiveness of a brief intervention parenting skills training program, *1-2-3 Magic*, for parents and carers of children identified as having suffered moderate to severe forms of abuse and neglect, or those at risk of abuse and neglect with carers reporting parenting stress;
- Operationally trial this type of parenting program with parents/carers of at risk children currently being referred by the NSW Department of Community Services to NCAHS for PANOC Counselling services;
- Improve the parenting self-esteem and skills of carers of children; and,
- Decrease reported parent/carer levels of anger, depression, and stress which are considered to be negative contributors to dysfunctional parenting style (Schumacher, Slep & Heyman, 2001).

5. METHODOLOGY:

5.1 The Project Proposal

The project proposal was developed by the research team, Rosemaria Flaherty and Rod Cooper. The project was a rural based pilot trial looking at the relative effectiveness of a short-term, evidence-based parenting skills training program delivered to parents/carers of children who have experienced, or are at risk of child abuse. The proposal, titled "The effectiveness of a parenting skills program in a rural Australian child protection setting", was then submitted to the NCAHS Human Research Ethics Committee for approval.

After some minor rewording of the questionnaire items and changes to the participant information form, the project was approved by the ethics committee to proceed. This approval was granted on the 16th April, 2007.

5.2 Research Team

The research team comprised of the Principal Investigator, Rosemaria Flaherty (PANOC Psychologist, NCAHS), and Rod Cooper, the Associate Researcher and Expert Mentor of Rosemaria. This formal mentoring arrangement was negotiated through the NSWIRCST.

After receiving permission to proceed with the research from the NCAHS Human Research Ethics Committee, the research phase commenced in July, 2007 and ceased in October, 2007.

5.3 Project referral System

Participants for the study were recruited from: Department of Community Services (where the DoCS Caseworker decided that a child's parent/carer would benefit from a parenting program); the local counselling service waitlist operating at the Grafton and Maclean Community Health Centres; the local Women's Refuge; Family Youth Support Service; and, the Pharmacotherapy Unit.

Parents/caregivers who met the inclusion criteria below were given a Participant Information Sheet by either a DoCS Caseworker or Community Health Counsellor. A verbal explanation of the information sheet provided maximum opportunity to ensure informed consent was obtained. During this explanation, legislative requirements (including the limits to confidentiality and duty of care), were explained. Parents/caregivers who indicated an interest to proceed were then requested to complete a consent form to participate. Participation was entirely voluntary.

When consent to participate was received by the Principal Researcher, the parents/carers were randomly allocated into groups (description of method following) and then contacted by the Principal Researcher to organise appointments for the pre-intervention assessment.

5.4 Selection of Project Participants

Participants referred to the program were then assessed by the following inclusion and exclusion criteria.

Inclusion criteria:

- Parent/carer referrals where child abuse or neglect had been substantiated or suspected (this included children living with birth parents or out of home carers such as foster carers, relatives or kinship carers); and,
- Parents/carers of at risk children aged between 3 and 12 years who have reported parenting stress.

Exclusion criteria:

- Parents/carers whose primary language was other than English
- Parents/carers under the age of 18 years of age
- Parents/carers identified as having an intellectual or mental impairment; and,
- Parents/carers who belonged to a collective, for example, an employed 'group' of foster or respite carers.

Originally, 55 participants were referred to the program. 38 participants were successfully recruited. Unfortunately three participants dropped out of the study and were not able to be located to ask why they dropped out. Their data was not used in the final analysis.

Several commonalities were noted in the referrals and self-report of the parents/carers and children referred to the *1-2-3 Magic* project. These are listed below.

Commonalities among parents/carers referred

- Had been invited to participate in previous groups but the numerous program sessions meant non-completion of the course
- Needed courses to be run at different times of day and night
- Wanted help for "managing behaviour"

- Parents required to be hyper-vigilant to children's behaviour due to intensity and dangerousness of child behaviour.

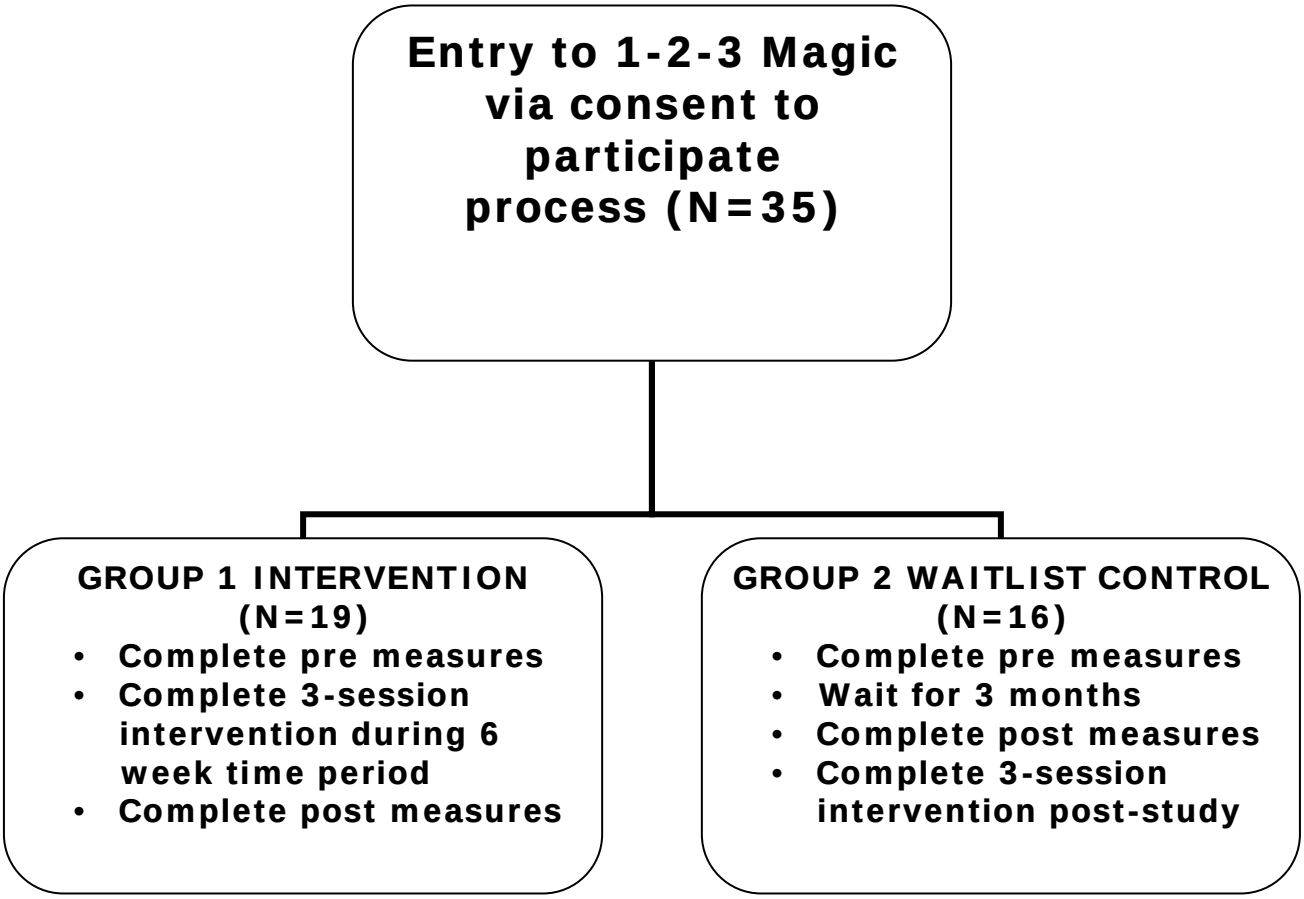
Commonalities among children being cared for

- Often the children were seeing a counsellor for therapeutic intervention or were on a waiting list to see a counsellor
- Histories of Domestic Violence, Sexual Assault, Neglect, Physical Abuse, Verbal Abuse
- One or both biological parents in gaol
- Child behaviour described as: 'chucks tantrums'; displaying aggressive behaviour such as, child kicks holes in the walls; older siblings abusing younger siblings
- Child clinical diagnoses of Anxiety, Attention Deficit Hyperactivity Disorder, Depression, Oppositional Defiance Disorder, Conduct Disorder, Complex Post-Traumatic Stress Disorder
- History of several medical interventions for illnesses.

5.5 Allocation to groups

Participants were randomly allocated to either an intervention group or a waitlist control group. The method employed to do this was by using a non-involved colleague to randomly allocate participants names to either group using a "drawing a name out of a hat" approach (Kerr et al., 2004).

Flowchart outlining the way participants proceeded through the research study.



Demographics

The intervention and waitlist control groups were not matched. There were differences in sex; identification as Aboriginal or Torres Strait Islander descent; and, education. However, there was no significant difference between employment and marital status (see Appendix 4). There were a total of 35 parent/carer participants caring for 99 children who made up the number of final participants in the project.

Type of abuse

77% of families indicated multi-abuse types suffered by the children in their care. Thirty two of 35 families reported a child or children in their care had suffered emotional and psychological abuse. Twenty five families reported that the child in their care had been exposed to domestic violence. Fourteen families identified the child had been neglected, 11 families reported known physical abuse and 8 families reported known sexual abuse histories.

5.6 Pre Intervention Assessments

Assessment of the intervention effect was measured by the pre to post changes in outcome variables on the following self-report measures:

- The Depression, Anxiety, Stress Scale (DASS) (Lovibond & Lovibond, 1995a) was used to assess parent/carer emotional state.
- Unwanted or undesirable child behaviour was measured using the Eyberg, Child Behaviour Inventory (ECBI) (Eyberg & Pincus, 1999).
- Determining the parent/carer's overall degree of satisfaction with parenting was measured with the Parenting Satisfaction Scale (PSS) (Guidubaldi & Cleminshaw, 1994); and,
- Three dysfunctional parenting styles were measured using the Parenting Scale (PS) (Arnold, O'Leary, Wolff & Acker, 1993).

In the instances where participant literacy level was problematic, the questions were read aloud to participants.

5.7 *1-2-3 Magic Parenting Program* outline

Group sessions were two hours duration with a short tea break. Groups were run from Grafton locations and in Yamba, which is 65 kilometres north of Grafton. Participants would arrive at the group time. They would proceed to settle their child/children into the childcare room and then attend the group room. Groups were held in the morning, afternoon and evening on different days of the week. Several dates were offered for each session so that if a parent/carer could not attend at their scheduled time, they could fit into another session within the 6 week timeframe.

The *1-2-3 Magic* program consisted of three sessions as outlined below.

Session #1:

- Introduction of the facilitator and group members
- Proceed through Session visual slides about: Child development and developmentally appropriate expectations; Children are not little adults; No-Talk, No-Emotion Rules
- Ten minute Morning, Afternoon or Evening snack break
- Re-convene group and proceed through remainder of session content.

Session #2:

- Testing and manipulation
- Pattern change and children's resistance to change
- Response flexibility in parents
- The Four option model – do nothing, listen and empathise, *1-2-3 Magic* option and watch DVD and listen and count.

Session #3:

- Controlling unwanted behaviour and encouraging good behaviour - different tactics
- Finishing off *1-2-3 Magic*
- More on *1-2-3 Magic* at home and in public

  E.g.: What it is used for and what it is not used for
  How it is done properly
  How to implement it in public

How to avoid the two biggest mistakes of parenting

- More on the listen and empathise option
- Introduce 'start' behaviour

5.8 Post Intervention Assessments

Intervention group

After completing the three session intervention, appointments were scheduled with parents/carers to complete the post-intervention questionnaires. These questionnaires were the same questionnaires completed prior to beginning the *1-2-3 Magic* program.

Waitlist control group

The participants in the three-month waitlist control group also completed the questionnaires at the same time the post-intervention group did - without having had any intervention. After completion of the questionnaires, the waitlist control group members were offered the 3-session *1-2-3 Magic* program.

5.9 Project Closure

At the commencement of participant recruitment, the community and referral agencies had the exact dates of closure of the project. Referrers and other parents/carers who had heard about the program via the 'grapevine' (that often exists in rural areas) were advised of the very specific timeframe and funding of the project.

There was a high level of interest in, and demand for, this program by community members and child and family services providers. The project continued to receive requests for ongoing *1-2-3 Magic* groups to be offered by the Community Health Centre.

Whilst a waiting list was not kept for future groups until Community Health Management approved further running of the groups, there

were over 30 parents/carers who had expressed an interest in attending a future group.

The Principal Researcher is still receiving requests to continue the groups. Currently, the proposal to continue offering the groups has been supported by Management and another staff member is being trained to deliver the *1-2-3 Magic* program.

5.10 Extra Activities

The preliminary findings of the research were presented at the 4th Biennial NSW PHC Research and Evaluation Conference, Sydney in November 2007. Further to this, requests were made of the Principal Researcher to: speak at an Australian Breastfeeding Association group in an isolated community; provide the *1-2-3 Magic* group ongoing in the Community Health Centre context; and, provide information about the *1-2-3 Magic* program to child care workers at a large non-government organisation providing family support services to at-risk families. The researchers are currently preparing an article manuscript for publication in an acceptable peer reviewed journal.

6. PARTNERSHIPS DEVELOPED:

Partnerships were developed and solidified via the operation of this program with local government and non government organisations. In particular, partnerships with the referral agencies listed in Section 5.3 of this report were strengthened as evidenced by the maintenance of higher referral rates of clients after the project had finished.

7. BARRIERS TO IMPLEMENTATION:

There were no barriers to implementation that were not overcome in this project. The schedule of assessment and intervention needed to be flexible resulting in a high work load for the researcher.

It is important to remember basic project management principles when offering such a program and to ensure the organisation has all of the necessary resources to provide the program. These include things like a portable combined TV & DVD player, tea and coffee making facilities on site and an overhead or Power Point projector in good working order.

8. RESULTS:

8.1 Process of Analysis

Data from the self-report questionnaires was de-identified with number codes provided for individuals. Data was then entered into Excel Spreadsheets configured for each measure in each of the groups.

A NSW Health Biostatician was allocated by the NSWIRCST to analyse the results.

8.2 Outcomes

Several female carers made the comment that the program should be offered to women in antenatal classes and this is consistent with what policies on parenting programs suggest (Policy Brief: Royal Children's Hospital, 2007).

Outcome measures

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 nine are considered Moderate and Stress scores above 18 are also Moderate.

Figure 1 shows the pre and post changes in the scores for the intervention group. Mean raw scores ($p < 0.01$) of: Depression reduced

from 14.3 (Std. Error 2.4) to 5.6 (1.2); Anxiety reduced from 5.6 (1.3) to 2.6(0.7); and Stress reduced from 18.0(2.7) to 10.4(1.4).

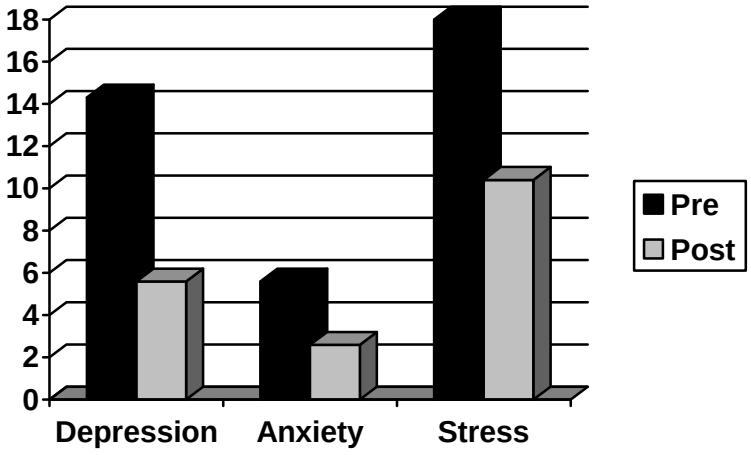


Figure 1: Mean "Pre" and "Post" scores for Parent/Carer Depression, Anxiety and Stress scores in the intervention group.

Parent/carer severity ratings as a group changed pre to post intervention from Moderate to Normal for Depression; Normal for Anxiety; and, 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 reduced from 15.8(2.3) to 20.3(3.1).

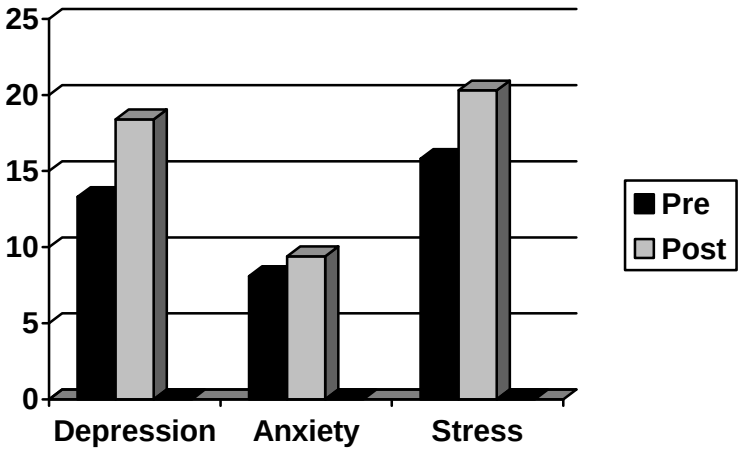


Figure 2: Mean "Pre" and "Post" scores for Parent/Carer Depression, Anxiety and Stress scores in the waitlist control group.

Parent/carer severity ratings as a group changed pre to post control from Mild to Moderate for Depression; Mild for Anxiety; and, Mild to Moderate for Stress.

The mean pre and post-intervention ECBI scores are presented in Table 1. 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 at $p<0.01$ on T-Score I and T-Score P. Intensity cut-off scores are at 131-133. Problem cut-off scores are at 15.

Table 1. Pre and post intervention group scores on the Eyberg Child Behaviour Inventory (ECBI) reported by carers.

ECBI score	Pre		Post	
	Mean	**(SError)**	**Mean**	**(SError)**
Intensity	165.1	(9.8)	144.2	(9.0)
Problem	23.2	(1.4)	15.6	(1.6)

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 are presented in Table 2.

Table 2. Pre and post waitlist control group scores on the Eyberg Child Behaviour Inventory (ECBI) reported by carers.

ECBI score	Pre		Post	
	Mean	**(SError)**	**Mean**	**(SError)**
Intensity	147.9	(12.8)	152.3	(10.9)
Problem	19.4	(2.1)	20.1	(1.8)

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 3.2, the Over-reactivity Factor higher than 4.0 and the Verbosity Factor higher than 3.4 (Arnold, O'Leary, Wolff & Acker, 1993). The mean pre and post-intervention PS scores are presented in Table 3.

Table 3. Pre and post intervention group scores on the Parenting Scale (PS) reported by carers.

PS score	Pre		Post		T-test (2 sided)
	Mean	**(SError)**	**Mean**	(SError)	
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

Intervention group scores show that the clinical cut-off was exceeded only on the pre Verbosity Factor score. However, all Factors reduced post intervention.

Waitlist control group scores are presented in Table 4.

Table 4. Pre and post waitlist control group scores on the Parenting Scale (PS) reported by carers.

PS score	Pre		Post		T-test (2 sided)
	Mean	**(SError)**	**Mean**	(SError)	
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

Waitlist control group scores show that the clinical cut-off was exceeded only on the pre Verbosity Factor score as well. However, all Factors were 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), percentile rank of 20%, to post = 126.2 (2.9), percentile rank of 42%.

Whereas, the waitlist control group scored a total pre parenting satisfaction of 112.3 (4.4), percentile rank of 16% and post parenting satisfaction decreased to 101.1 (5.8), percentile rank of 6% satisfaction.

9. DISCUSSION & CONCLUSION:

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/carers of children who have experienced abuse, was supported.

DASS results however, showed that the intervention group had higher levels of depression, anxiety and stress before the intervention compared to the waitlist control group. Conversely, the participants in the waitlist group while not as stressed to start with, but as they waited, their stress levels increased. This result could be explained by an 'intent to treat' factor where the parents/carers feel they have asked for help and will receive it, but then have to wait to receive the assistance.

ECBI intervention group scores for the Intensity of the child's behaviour exceeded the cut-off on both the pre and post intervention questionnaires. Post intervention ECBI scores were still well above clinical cut-off. This may mean that the abused children's behaviour will likely result in high scores on this measure.

ECBI intervention group scores 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) statement that the less problem behaviours are reported by the carer the more confident the parent becomes 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 scores show both pre-group scores were similar. 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 group coupled with the small group participant numbers, resulted in the intervention having 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 learning facts about child development and how that knowledge changed their parenting 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 ranks, were surprising. Both groups were very similar in their pre parenting satisfaction levels, however the waitlist group showed a marked decrease in parenting satisfaction, and a marked increase in stress and dysfunctional parenting style as they waited for intervention.

Scores on all the clinical measures were significantly high on the questionnaires prior to the intervention. The waitlist control group deteriorated over the three 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.

Carers were a disparate group with different coping styles and different resources. Both groups reported similar levels of carer stress and child behaviour problems. However, the intervention group showed an increase in parenting satisfaction, and a reduction in depression, anxiety, stress and unwanted child behaviour. The average carer age for the groups was 43 years of age (intervention group) and 36 years (waitlist control group). This begs the question of whether this type of program is being offered early enough in the parenting experience when a lot of parents are much younger than the mean participant age of 43 years in the intervention group.

Three of the participants in this study dropped out. The participants could not be located to ask why they dropped out of the study. One of the confounders of this study is that this dropout rate could be related to rural factors that are not necessarily reflected in the study design.

Retention of participants in parenting groups is difficult – particularly when the program is run over a number of weeks. This study shows that carers can indeed be retained over the three sessions of a 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 difference to the experience of 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 the Department of Community Services and services receiving those referrals need to be configured to meet that need. Therefore, the *1-2-3 Magic Parenting Program* could be used, at minimum, as an educational tool with referred 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 very small sample size. Due to resource issues in the Community Health service and the size of the scholarship fund, the researcher fulfilled the roles of both assessor and program facilitator as well. Program fidelity was attempted to be maintained by the materials (visual slides, *1-2-3 Magic Parenting Program* book, DVD and session outlines) being standardised and, all pre and post measures were completed.

Another weakness of the design of the study is that the responses to the questionnaires are dependent entirely on self report. An additional research design bias was that participants may have reported positive results due to 'getting together' as a group, rather than purely benefiting from the educational content of the sessions. Whilst the group was intended as an educational rather than therapeutic group, the supportive nature of the group may have caused participants to

feel more confident in their parenting role as time progressed. In addition to this, the intervention group may have been anticipating an intervention thus inflating true changes attributable to the actual program.

Conclusion

Parenting issues are one of the most common referrals for services in 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 intervention to offer parents and carers of abused children. Reduction in some of the known parenting stressors related to child abuse occurred. Carers readily report sometimes using a coercive parenting style with an already vulnerable population of children. However, the efficacy of the program as a treatment intervention needs larger scale longitudinal research to control for confounding variables and the small sample size as well as to track the maintenance of the improvements made over time. *1-2-3 Magic Parenting Program's* potential effectiveness may be as a first level intervention for parenting difficulties.

10. SUSTAINABILITY:

This program has shown some promising preliminary improvements in parents/carers emotional health when caring for abused children. The *1-2-3 Magic Parenting Program* is easy to run and takes minimal time for trained facilitators to comfortably deliver the program in a standardised way.

The key adjunct components to the group's success were the coordinated transport to the sessions and the food and childcare provided.

Therefore, the program is sustainable with small budget implications.

11. REFLECTIVE ANALYSIS:

A main concern at the outset of the study was whether low literacy and education levels would hinder some carers in grasping the program's content. Carers demonstrated a sound understanding of the course content by actively participating in the sessions and discussing their parenting homework at the commencement of each subsequent session.

Applied research is very difficult to do in the Community Health setting. Recruitment and retention of participants for the study were the main challenges. The target group of this study was a difficult group to engage due to the disadvantages families face such as not having secure housing, transport, child care, or income coupled with high stress levels. It was difficult to obtain large participant numbers for the study, particularly within the time limits of the scholarship fund.

The potential for burn-out of clinicians doing research in an isolated setting is high. Specialist positions are not able to be backfilled easily – particularly in rural areas where there is a shortage of staff and many unfilled positions. In addition, there is a potential for the clinician to burnout without proper support, due to the need to cope with the extra demands of continuing their clinical work and research concurrently. There are also likely sources of bias introduced to the study when the clinician becomes the researcher as well the program facilitator.

Self discipline, time management skills and organisational skills are required to complete this type of project work. Whilst one day per week was dedicated to the research, the actual 'work' is spread across the whole week as clients and service providers don't all return telephone calls on the particular day allocated as a 'Research' day.

Many positives came out of the research study process. In particular the highlights were being part of a group of scholars with academic support networks, attendance at The 2007 Rural Research Health Research Colloquium, Tamworth and drafting a paper to submit for publication. The first draft of this manuscript was submitted recently to the University Department of Rural Health's writers group for expert peer feedback, a process I was able to participate in via teleconference.

While the project was very resource intensive with one person fulfilling all roles, it is encouraging to think that small research projects can benefit health services by recommending programs designed for community needs.

12. BUDGET EXPENDITURE AND TIMEFRAME:

The budget was based on a backfill of clinical position model. That is, the wages component of one day per week clinical backfill of the PANOC Psychologist position were reimbursed to the NCAHS by the NSWIRCST. Further, $1000.00 per year discretionary project funds were used to run the program including the purchasing of some of the self-report questionnaires. This amount also came from the NSWIRCST scholarship fund.

Transport to the parenting group was provided by the workers from the agency referring the parent/carer. Morning, Afternoon and evening snacks were provided as was childcare. On one occasion in the school holidays, the venue of the group had to be changed as there were 12 children in childcare whilst the parents/carers participated in the group.

The project budget was achieved and the project was implemented in the predicted timeframe.

13. RECOMMENDATIONS:

It is recommended that the *1-2-3 Magic Parenting Program* continue to be provided by the local Community Health Centre. Over time, perhaps an interagency approach can be developed where there is agreement to run the program with interagency staff on a rotational basis. In addition to this leading recommendation, the following two recommendations are made:

1. Funding for a larger research grant be sought to expand the capacity of the study to include a larger amount of participants and longitudinal follow-up about whether the improvements to parent/carer parenting style are lasting; and,
2. Other clinicians within various teams such as Child and Family Counselling, Sexual Assault and Child and Family Health Nurses be trained as *1-2-3 Magic Parenting Program* Facilitators.

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APPENDICES

1. **Participant information form**
2. **Consent form**
3. **Ethics approval letter**
4. **Demographic characteristics of the 2 groups**
5. **DASS**
6. **Arnold Parenting Scale**

Research funded by
NSW Institute of Rural Clinical Services and Teaching
NSW HEALTH

Appendix 1

NORTH COAST AREA HEALTH SERVICE NSW HEALTH

1-2-3 Magic Parenting Program

Dear Parent/Carer,

You are invited to participate in a parenting research project being undertaken at the Grafton and Maclean Community Health Centres of the North Coast Area Health Service (NCAHS). The project has two objectives:

1. To provide a 3 session parenting program called "1-2-3 Magic" and examine if it increases parent/carer satisfaction in the parenting/caring role; and,
2. To reduce the levels of reported anger, depression and stress felt by the parents/carers.

The 1-2-3 Magic program will be provided by Rosemaria Flaherty.

How were potential participants selected?

You have either been referred by the Department of Community Services (DoCS) or are on a Community Health Centre waitlist after requesting parenting assistance.

What does the study involve?

The focus of the study is to see how parents/carers are feeling about their caring role before the 1-2-3 Magic program and then again after the 1-2-3 Magic program. This project will take around 12 months to complete and will involve around 50 families within the Clarence Valley.

2 groups will be required for the study. Group 1 will receive the 1-2-3 Magic program immediately upon referral to the program and Group 2 will wait 3 months to receive the 1-2-3 Magic program. Group 2 is called a waitlist control group. Participants are **randomly assigned** to groups. This is an additional service that is not usually available and choosing to participate, or not, will not impact on your access to Community Health services. The process of assignment to either group is a way of providing a service to all people within the study in a fair way.

Participants will complete 4 standard questionnaires covering parenting topics and these are:

1. Depression Anxiety and Stress Scale
2. Eyberg Child Behaviour Inventory
3. Parenting Satisfaction Scale &
4. Parenting Scale

These measures will be completed twice by participants. Once before completing the program and once after the program has been received. The 1-2-3 Magic program itself requires attendance at 3 sessions. If you decide to take part, the sessions will be conducted at the Community Health Centre.

Other supporters:
NORTH COAST AREA HEALTH SERVICE NSW HEALTH & THE UNIVERSITY OF NEWCASTLE AUSTRALIA

Can I withdraw from the study?

Participation in this study is completely voluntary – you are under no obligation to consent. Furthermore, you can withdraw your consent at any time without prejudice.

Will anyone else know what I said in the questionnaires?

Information collected is strictly confidential. Only the researcher will have access to the information provided by you, about you. The results of this study will be written up however individual participants will not be identified in any publication.

Will the study benefit me?

1-2-3 Magic has been proven to help parents/carers feel better skilled to deal with behaviour problems in children/young people. Having a parenting program that reliably shows an improvement in parent/carer satisfaction will hopefully assist in better outcomes for the children/young people in your care.

What if I require further information?

If you wish to find out more about the research please call the Project Coordinator, Rosemaria Flaherty on 02 66402402.

If you are willing to take part in this research project, please contact Rosemaria on the phone number above.

Thankyou for your interest in this research project.

Any person with concerns or complaints about the conduct of the research study can contact the NCAHS Ethics Committee on: 02 65882941

R Flaherty
Prevention of Abuse & Neglect Counsellor
Grafton Community Health
NCAHS

Research funded by

Appendix 2

1-2-3 Magic Parenting Program

Dear Parent/Carer,

The North Coast Area Health Service (NCAHS) will be conducting a research parenting program as part of the Community Health Service this year. The program will support parents and carers to manage difficult behaviour in children. There are 2 research groups and you will be randomly assigned to the immediate intervention group, or the 3 month wait list group.

We would like to evaluate the effect of this program by surveying participating parents/carers levels of anger, depression and stress before and after the intervention as well as asking you to comment on your child's behaviour. The surveys are self-report questionnaires that you complete. They will take about 60-90 minutes to complete. Your results will not be given to anyone else but they will be made available to you.

Participation in the evaluation is voluntary and you may withdraw your participation at any time without penalty or prejudice. All information provided will be treated confidentially and the results of the questionnaires will only be presented in a grouped format. No individuals will be identifiable in any report.

Please fill in and detach the permission slip below and return it to Rosemaria Flaherty next time you are at the Community Health Centre.

If you would like any more information about this please telephone me on 02 66402402.

The NCAHS Human Research Ethics Committee has approved this research project. Any complaints or concerns about this research project may be made to the committee through:
Research Ethics Officer
NCAHS Human Research Ethics Committee
PO Box 126
Port Macquarie NSW 2444
Ph: 0265882941 Fax:: 026588 2942 Email: EthicsNCAHS@ncahs.health.nsw.gov.au

Thankyou for your time and your help

Rosemaria Flaherty
Project Coordinator
::

PLEASE COMPLETE

□ I agree to participate in the study according to the information given to me in the Information Sheet.

Signed:
Print name:
Date:
Contact phone number & postal address:

Page 1 of 1

Other supporters:

&

Research funded by

Appendix 3

NORTH COAST
AREA HEALTH SERVICE
NSW HEALTH

16 April 2007

Rosa Flaherty
Child Protection Counsellor
Grafton Community Health
NCAHS
PO Box 368
Grafton NSW 2460

Dear Rosa

RE: NCAHS HREC NO. 399N

1-2-3 Magic Parenting Program: Trialling a parenting skills program in a rural Australian Child Protection setting

Thank you for your correspondence of 30 March 2007 to the North Coast Area Health Service (NCAHS) Human Research Ethics Committee (HREC).

The Chair reviewed and approved the clarifications along with amended Participant Consent Form.

Documentation received and approved in relation to the above study is as follows:

- Ethics application
- Management approval
- Privacy Questions
- Research Protocol
- Participant Information Statement
- Consent Form- amended
- Questionnaires:
  The Depression, Anxiety, Stress Scale
  Eyberg Child Behaviour Inventory
  Parenting Scale

The NCAHS HREC is constituted and operates in accordance with the National Health and Medical Research Council's *National Statement on Ethical Conduct in Research Involving Humans (National Statement).*

Final approval to commence the 1-2-3 Magic Parenting Program study has now been granted.

As part of this approval, the following must be provided to the NCAHS HREC:

Amendments and Reporting of Serious Adverse Events

Human Research Ethics Committee
Clinical Governance Unit
North Coast Area Health Service
PO Box 126, Port Macquarie NSW 2444
Tel (02) 6588 2941 Fax (02) 6588 2942
Website www.ncahs.nsw.gov.au
ABN 37 940 606 983

Research funded by

Researchers should immediately report anything to the Research Ethics Committee which might warrant review of ethical approval of the protocol, including;

- *Serious or unexpected adverse effects on **local** participants (reports to be de-identified);*
- *Proposed changes in the protocol or any other material given to the participants in the study must be known prior to being actioned, including patient information and consent forms; and*
- *Unforeseen events that might affect continued ethical acceptability of the project.*

Study Progress Reports

At least annually, reports from principal researchers should be submitted to the Research Ethics Committee on matters including;

- *Progress to date or outcome in the case of completed research;*
- *Maintenance and security of records;*
- *Compliance with the approved protocol;*
- *Compliance with any conditions of approval*
- *If the research project is discontinued before the expect date of completion*
-

It is requested that updated Patient Information Consent Forms that are approved by the HREC, to be forwarded to all patients on the Trial.

Please quote **399N, short and full study name** in all correspondence and ensure all documentation relating to this study is forwarded, with original and required number of copies () being **doublesided and 2-hole punched,** to:

Human Research Ethics Committee
North Coast Area Health Service
PO Box 126
PORT MACQUARIE NSW 2444

On behalf of the NCAHS HREC I wish you all the best with your research.

If you wish to discuss any matters further, please contact me on 02 6588 2941.

Yours sincerely

Val Johnstone
Research Ethics Officer
Human Research Ethics Committee

Human Research Ethics Committee
Clinical Governance Unit
North Coast Area Health Service
PO Box 126, Port Macquarie NSW 2444
Tel (02) 6588 2941 Fax (02) 6588 2942
Website www.ncahs.nsw.gov.au
ABN 37 940 606 983

Appendix 4

Demographic characteristics of the 2 groups

Variable	Control Group N=16		Intervention Group N=19		Fisher's exact Test p<0.05
SEX	**n**	**%**	**n**	**%**	
Female	15	93.8	13	68.4	**p=0.10**
Male	1	6.3	6	31.6	
ATSI					
Yes	5	31.3	1	5.3	**p=0.07**
No	11	68.8	18	94.7	
EDUCATION					
<Year 10	4	25.0	2	10.5	**p=0.43**
Year 10	5	31.3	2	10.5	
Year 12	1	6.3	3	15.8	
Trade	0	0.0	1	5.3	
Certificate	5	31.3	8	42.1	
Degree	1	6.3	1	5.3	
Post Graduate	0	0.0	2	10.5	
EMPLOYMENT					
Employed	1	6.3	4	21.1	p=0.045
Unemployed	2	12.5	4	21.1	
Retired	0	0.0	4	21.1	
Student	2	12.5	3	15.8	
Household	11	68.8	4	21.1	
Other	0	0.00	0	0.0	
MARITAL STATUS					
Single	9	56.3	4	21.1	p=0.02
Married	2	12.5	11	57.9	
Divorced	2	12.5	3	15.8	
Separated	3	18.8	1	5.3	
Widowed	0	0.0	0	0.0	

DASS

Name: *Date:*

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you *over the past week*. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

0 Did not apply to me at all
1 Applied to me to some degree, or some of the time
2 Applied to me to a considerable degree, or a good part of time
3 Applied to me very much, or most of the time

1	I found myself getting upset by quite trivial things	0	1	2	3
2	I was aware of dryness of my mouth	0	1	2	3
3	I couldn't seem to experience any positive feeling at all	0	1	2	3
4	I experienced breathing difficulty (eg, excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3
5	I just couldn't seem to get going	0	1	2	3
6	I tended to over-react to situations	0	1	2	3
7	I had a feeling of shakiness (eg, legs going to give way)	0	1	2	3
8	I found it difficult to relax	0	1	2	3
9	I found myself in situations that made me so anxious I was most relieved when they ended	0	1	2	3
10	I felt that I had nothing to look forward to	0	1	2	3
11	I found myself getting upset rather easily	0	1	2	3
12	I felt that I was using a lot of nervous energy	0	1	2	3
13	I felt sad and depressed	0	1	2	3
14	I found myself getting impatient when I was delayed in any way (eg, lifts, traffic lights, being kept waiting)	0	1	2	3
15	I had a feeling of faintness	0	1	2	3
16	I felt that I had lost interest in just about everything	0	1	2	3
17	I felt I wasn't worth much as a person	0	1	2	3
18	I felt that I was rather touchy	0	1	2	3
19	I perspired noticeably (eg, hands sweaty) in the absence of high temperatures or physical exertion	0	1	2	3
20	I felt scared without any good reason	0	1	2	3
21	I felt that life wasn't worthwhile	0	1	2	3

Please turn the page ☞

Reminder of rating scale:

0 Did not apply to me at all
1 Applied to me to some degree, or some of the time
2 Applied to me to a considerable degree, or a good part of time
3 Applied to me very much, or most of the time

22	I found it hard to wind down	0	1	2	3
23	I had difficulty in swallowing	0	1	2	3
24	I couldn't seem to get any enjoyment out of the things I did	0	1	2	3
25	I was aware of the action of my heart in the absence of physical exertion (eg, sense of heart rate increase, heart missing a beat)	0	1	2	3
26	I felt down-hearted and blue	0	1	2	3
27	I found that I was very irritable	0	1	2	3
28	I felt I was close to panic	0	1	2	3
29	I found it hard to calm down after something upset me	0	1	2	3
30	I feared that I would be "thrown" by some trivial but unfamiliar task	0	1	2	3
31	I was unable to become enthusiastic about anything	0	1	2	3
32	I found it difficult to tolerate interruptions to what I was doing	0	1	2	3
33	I was in a state of nervous tension	0	1	2	3
34	I felt I was pretty worthless	0	1	2	3
35	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
36	I felt terrified	0	1	2	3
37	I could see nothing in the future to be hopeful about	0	1	2	3
38	I felt that life was meaningless	0	1	2	3
39	I found myself getting agitated	0	1	2	3
40	I was worried about situations in which I might panic and make a fool of myself	0	1	2	3
41	I experienced trembling (eg, in the hands)	0	1	2	3
42	I found it difficult to work up the initiative to do things	0	1	2	3

PARENTING SCALE (ARNOLD)

Instructions: At one time or another, all children misbehave or do things that could be harmful, that are " wrong", or that parents don't like. Example include:

hitting someone	whining	not picking up toys
forgetting homework	throwing food	refusing to go to bed
having a tantrum	lying	wanting a cookie before dinner
running into the street	arguing back	coming home late

Parents have many different ways or styles of dealing with these types of problems. Below are items that describe some styles of parenting.

For each item, fill in the circle that best describes your style of parenting during the past two months with the **target child**.

SAMPLE ITEM:

At meal time…

I let my child decide how much to eat.	**0---0---●---0---0---0---0**	I decide how much my child eats.

1. When my child misbehaves…

I do something right away.	**0---0---0---0---0---0---0**	I do something about it later.

2. Before I do something about a problem…

I give my child several reminders or warnings.	**0---0---0---0---0---0---0**	I use only one reminder or warning.

3. When I'm upset or under stress…

I am picky and on my child's back.	**0---0---0---0---0---0---0**	I am no more picky than usual.

4. When I tell my child not to do something…

I say very little.	**0---0---0---0---0---0---0**	I say a lot.

5. When my child pesters me…

I can ignore the pestering.	**0---0---0---0---0---0---0**	I can't ignore pestering.

6. When my child misbehaves…

I usually get into a long argument with my child.	**0---0---0---0---0---0---0**	I don't get into an argument.

7. I threaten to do things that…

I am sure I can carry out.	**0---0---0---0---0---0---0**	I know I won't actually do.

8. I am the kind of parent that…

set limits on what my child is allowed to do.	**0---0---0---0---0---0---0**	lets my child do whatever he/she wants.

9. When my child misbehaves…

I give my child a long lecture.	**0---0---0---0---0---0---0**	I keep my talks short and to the point.

10. When my child misbehaves…

I raise my voice or yell.	**0---0---0---0---0---0---0**	I speak to my child calmly.

11. If saying "No" doesn't work right away…

I take some other kind of action.	**0---0---0---0---0---0---0**	I keep talking and try to get through to my child.

12. When I want my child to stop doing something…

I firmly tell my child to stop.	**0---0---0---0---0---0---0**	I coax or beg my child to stop.

13. When my child is out of my sight…

I often don't know what my child is doing.	**0---0---0---0---0---0---0**	I always have a good idea of what my child is doing.

14. After there's been a problem with my child…

I often hold a grudge.	**0---0---0---0---0---0---0**	things get back to normal quickly.

15. When we're not at home…

I handle my child the way I do at home.	**0---0---0---0---0---0---0**	I let my child get away with a lot more.

16. When my child does something I don't like…

I do something about it. every time it happens.	**0---0---0---0---0---0---0**	I often let it go.

17. When there is a problem with my child…

things build up and I do things I don't mean to do.	**0---0---0---0---0---0---0**	things don't get out of hand.

18. When my child misbehaves, I spank, slap, grab, or hit my child…

never or rarely.	**0---0---0---0---0---0---0**	most of the time.

19. When my child doesn't do what I ask…

I often let it go or end up doing it myself.	**0---0---0---0---0---0---0**	I take some other action.

20. When I give a fair threat or warning…

I often don't carry it out.	**0---0---0---0---0---0---0**	I always do what I said.

21. If saying "No" doesn't work…

I take some other kind of action.	**0---0---0---0---0---0---0**	I offer my child something nice so he/she will behave.

22. When my child misbehaves…

I handle it without getting upset.	**0---0---0---0---0---0---0**	I get so frustrated or angry that my child can see I'm upset.

23. When my child misbehaves…

I make my child tell me why he/she did it.	**0---0---0---0---0---0---0**	I say "No" or take some other action.

24. If my child misbehaves and then acts sorry…

I handle the problem like I usually would.	**0---0---0---0---0---0---0**	I let it go that time.

25. When my child misbehaves…

I rarely use bad language or curse.	**0---0---0---0---0---0---0**	I almost always use bad language.

26. When I say my child can't do something…

I let my child do it anyway.	**0---0---0---0---0---0---0**	I stick to what I said.

27. When I have to handle a problem…

I tell my child I'm sorry about it.	**0---0---0---0---0---0---0**	I don't say I'm sorry.

28. When my child does something I don't like, I insult my child, say mean things, or call my child names…

never or rarely.	**0---0---0---0---0---0---0**	most of the time.

29. If my child talks back or complains when I handle a problem…

I ignore the complaining and stick to what I said.	**0---0---0---0---0---0---0**	I give my child a talk about not complaining.

30. If my child gets upset when I say "No"…

I back down and give in to my child.	**0---0---0---0---0---0---0**	I stick to what I said.