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# Parenting training in the community: linking process to outcome

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## Abstract

This pilot study examines the effectiveness of the Parents Together Community Course<sup>1</sup> (a six week preventative version of the Parents Plus Early Years Programme) in reducing parent-reported behaviour problems in pre-school and school aged children. It also investigates if there is an association between process ratings on a weekly session rating form (WSRF) and client outcome. Thirty-one parents who completed the course filled out pre and post outcome measures (namely the Strengths and Difficulties Questionnaire (SDQ) and a specially designed Client defined Problem and Goals form (CPG)), and a process measure during the course of the group. It was found that 45% of children in the community sample had behavioural problems in the borderline or clinical range, and significant reductions in these problem behaviours and gains towards parent-defined goals were observed following the course. Results also showed a number of correlations between high ratings on the WSRF and positive outcome as measured by the CPG and SDQ indicating a possible link between this process measure and outcomes. This highlights the importance of early community interventions in dealing with childhood behaviour problems and the possible utility of a process measure for identifying contributing factors to change.

## Keywords

frontline intervention, parent training, problem behaviours, process variable, rating form

## Introduction

### *Parent Training in the Community*

*Parent Training in Mental Health Services.* Serious behavioural problems in children constitute one third to one half of all referrals to child mental health services (Best & Dadds, 2007;

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Kazdin, 1995; Watt, Hoyland,; White & Verduyn, 2006). However, these problems are also the most difficult to treat and if not treated early, can leave these children at risk for a wide range of long term consequences. Up to 50% of behavioural problems in preschool children later develop into mental health problems, including oppositional defiant disorder, conduct disorder, and depression (Bar & Sanders, 2004; Campbell, 1995; Markie-Dadds & Sanders, 2006). Social costs also result such as delinquency, antisocial behaviour, increased school dropout and subsequent unemployment, crime and alcohol or drug problems (Barlow & Stewart-Brown, 2000; Roff & Wirt, 1985; Smith et al., 2002). In addition to the social costs to the individuals and their families, long-term problems often incur the cost of special education, social welfare, and child and adult health services (Hutchings, Lane & Kelly, 2004). The prevalence of these problems, their stability over time, their poor prognosis, and their costs to both individuals and the society, all point to the need for primary prevention and early effective interventions (Barlow & Stewart-Brown, 2000).

Research shows that a variety of factors surrounding children may have a strong impact on their behavioural and emotional development, including parenting style (Clark, Woodward, Fagot & Leve, 1998; Horwood & Moore, 2008; Suveg et al., 2008;) and some parenting variables have been associated with early antisocial behaviour and later delinquency (Campbell, 1995; Loeber & Hay, 1994; Patterson, Reid, & Dishion, 1993; Thornberry, Freeman-Gallant, & Lovegrove, 2009). It appears that parenting which involves inconsistent or harsh discipline, nagging, ineffectual commands, low warmth and punishment, with little positive parental involvement with the child, plays a significant role in the development and or maintenance of child behavioural problems (Campbell, 1995; Gardner, 1992; Hipwell et al., 2008; Kochanska & Aksan, 1995; Maccoby & Martin, 1983).

Parent training programmes are the most commonly used mode of intervention for addressing behavioural problems in children in mental health care settings (Carr, 1999; Kazdin, 2005; MacMillan, 2009). These are focused short-term interventions that typically aim to help parents deal with their children's emotional and behavioural development. At the management level, parenting programmes have been found to be more effective in reducing childhood mental health problems than drug treatment or individual psychotherapy (Campbell et al., 2004; Donner & Klar, 2000; Sanson et al., 1991). They have also been shown to significantly decrease conduct problems, increase prosocial behaviour, reduce parental stress and improve parent-child interactions (Daly, Jones, Hutchings & Thompson, 2009; Kazdin, 1997; Nixon, 2002; Serketich & Dumas, 1996; Taylor & Biglan, 1998). In particular, there is considerable evidence for parent training groups that follow social learning principles in decreasing childhood problematic behaviours (Patterson 1982; Sharry & Fitzpatrick, 1998; Webster-Stratton, 1992; Webster-Stratton & Reid, 1997; Webster-Stratton & Herman, 2008) and that these changes are maintained over time (Barlow & Stewart-Brown, 2000). Similar results have also been reported for parenting courses in community settings (Dumas et al., 2008; Hastings, 2006; Orrell-Valente et al., 1999).

**Parents Plus Early Years (PPEY) Programme.** The Parents Plus Early Years (PPEY) Programme (Sharry, Hampson, & Fanning, 2003) is one such programme, which was developed as a front line intervention for parents of pre-school children referred to child mental health services, with behavioural, emotional and developmental problems specifically targeted at children aged one to seven years old. The PPEY is one of three Parents Plus Programmes developed by the Parents Plus Charity covering the needs of preschool, primary school age and adolescent children.

The PPEY is a manualised parenting course that uses DVD footage of real parenting scenes and parent-child interactions, as a means of providing information to families in a manner which is accessible, familiar, immediate, and which does not demand literacy skills. The PPEY manual contains detailed session plans on presenting the DVD footage and using group discussion,

practice exercises, role-play and rehearsal as well as detailed handouts and homeworks sheets to assist parents applying the ideas at home. Delivered over eight to twelve weeks, the programme covers Positive Parenting topics such as: child-centred play and communication, encouraging and supporting children, helping children concentrate and learn, as well as Positive Discipline topics such as: establishing rules and routines, managing tantrums, misbehaviour and solving problems.

### **Parents Plus Programme Research Findings**

A number of studies have shown that the Parents Plus Programmes are effective in reducing childhood behaviour problems and associated parental stress in a variety of contexts with a variety of age groups (e.g. Behan et al, 2001, Coughlin, Sharry et al., 2009; Quinn et al 2006, Quinn et al 2007). In particular, the Parents Plus Early Years Programme has been shown to reduce conduct problems, hyperactivity and parental stress and to help parents move significantly closer to their goals when conducted in a clinical setting by mental health care professionals (Griffin, 2006; Sharry et al., 2005).

Parenting programmes such as the PPEY, however, are costly, require a great deal of therapist time and training, the clinical settings in which they are conducted are generally inaccessible for the majority of people in a community and some parents report feeling stigma attached to attending CAMHS, in which such programmes are typically help (Bradby et al., 2007). Given that child and adolescent mental health services are unlikely to meet the needs of all children with mental health problems in communities, preventative and more accessible programmes need to be put in place.

### **Parents Together Community Course**

The Parents Together Community Course is a six week preventative version of the Parents Plus Early Years Programme designed for delivery by frontline professionals with a two day facilitator training. The course was produced as a collaboration between the Parents Plus Charity and the Early Learning Initiative in the National College of Ireland. Although the NICE guidelines recommend running parenting programmes for at least eight weeks, and the PPEY typically runs over a 12 weeks period, it was decided to pilot this course over six weeks as it was deemed more practical in a community setting and the study aimed to assess if such a short-term intervention could have similar beneficial effects as have previously been found in longer-term programmes. The course comes with a detailed facilitator's manual and a special parent's booklet with information, worksheets and homework exercises for parents. Like the full programme, the course covers two topics during each weekly group session lasting two hours. See Figure 1 for a summary of the course topics.

The current pilot study attempts to assess whether the Parents Together Course, delivered over a short sixweek format and facilitated by frontline community professionals can be as effective as previous studies conducted in clinical settings, which have demonstrated a significant reduction in parent-reported behaviour problems (Griffin, 2006; Sharry et al., 2005).

### **Parent Training – Linking process to outcome**

**Rationale for process measures.** When evaluating group-work, it is important to measure both outcome and process variables to ensure that progress is being made, and also to identify the therapeutic conditions necessary for progress. Thus, ideally an evaluation should not just demonstrate

|   |
|---|
| SESSION 1   |
| <ul style="list-style-type: none"> <li>• Introduction/Tuning into Children</li> <li>• Pressing the Pause Button</li> </ul>  |
| SESSION 2   |
| <ul style="list-style-type: none"> <li>• Child Centred Play and Communication</li> <li>• Teaching Children How to Behave Well</li> </ul>                          |
| SESSION 3   |
| <ul style="list-style-type: none"> <li>• Encouraging and Supporting Children</li> <li>• The Power of Attention</li> </ul>   |
| SESSION 4   |
| <ul style="list-style-type: none"> <li>• Establishing Routines Using Rewards and Picture Charts</li> <li>• Gaining Co-operation from Children</li> </ul>          |
| SESSION 5   |
| <ul style="list-style-type: none"> <li>• Helping Children Learn Through Play and Reading Books</li> <li>• Dealing with Misbehaviour Using Consequences</li> </ul> |
| SESSION 6   |
| <ul style="list-style-type: none"> <li>• Creative Play Activities</li> <li>• Parents Caring for Themselves</li> </ul>   |

**Figure 1.** Course Topics

whether outcomes are achieved or not but also should identify what it was in the programme that led to the outcomes being achieved (Hogard, 2008). Although the efficacy of the PPEY in reducing behaviour problems and parental stress has been demonstrated (Griffin et al., 2005; Griffin, 2006), and other beneficial outcomes of parenting courses have been well documented and replicated (Barlow & Stewart-Brown 2000; Behan & Carr, 2000; Richardson & Joughin 2002), there is a definite lack of research into the processes by which parenting groups work and why some people benefit whilst others do not.

In addition, while effectiveness is evaluated on a group basis in parent training studies, there are many individuals that do not benefit and parent drop out is relatively common over the course of such programmes (e.g. Barkley et al., 2000; Kazdin, Mazurick, & Siegel, 1994). For example, 17% of parents did not complete the Parents Plus Programme for pre-school children in the study in 2006 (Quinn et al., 2006). This indicates that perhaps only those that are satisfied throughout the programme benefit and others may leave early without being any closer to their goals. This shows the need for processes to identify early on the clients that are struggling so therapists can judge the need for extra support or the appropriateness of alternative approaches. This means that they can intervene earlier to support them, prevent dropout and to better tailor their therapy. In addition, should process factors associated with positive change be identified, these factors could be examined in future to determine whether their presence can have a significant influence on client outcome.

**Development of Weekly Session Rating Form (WSRF).** One way to assess group process and to gain feedback about clients' progress during groups is by using session rating questionnaires. The Institute for the Study of Therapeutic Change (ISTC) recommend using questionnaires in individual therapy with clients in each session to establish with them if tangible progress is being made and whether the conditions for effective therapy are present (for example, agreement on goals and method and a good therapeutic alliance) (Duncan & Miller, 2000; Duncan et al., 2004; Miller et al., 2004). These questionnaires give the therapist the opportunity to tailor their therapy according to the client feedback and thus make it more effective. They propose that questionnaires may portray a more honest picture of how the client is feeling about their progress, as they may be reluctant to verbally report difficulties to the therapist.

Adopting a similar approach to the ISTC, we designed a brief Weekly Session Rating Form (WSRF), within a group format (Sharry, 2007) to give an indication of client progress and as to whether the conditions for positive change are present. The goal of the current study is to determine whether there is any correlation between scores on the WSRF and final outcome scores as measured by the SDQ and CPG. If this is shown to be the case, then the WSRF may be able to be used as a session by session indicator of client progress and allow the group facilitator to tailor their intervention in a similar way to in individual therapy as proposed by the ISTC above.

## Method

### Participants

Participants were children from various locations throughout the country, whose parents were recruited through Home School Community Liaison teachers or Family Support workers to a Parents Together Community Course.

### Measures

One standardised questionnaire measure was incorporated into the research. This was filled out at the beginning of the six-week PTCC and again at the end. The measure is described below.

**Strengths and Difficulties Questionnaire (SDQ).** This scale developed by Goodman (1997) contains 25 items measuring five aspects of a child's behaviour; emotional symptoms, conduct problems, hyperactivity, peer problems and prosocial behaviour. Each subscale contains five items and scores range from 0 to 10. Parents were asked to indicate how true each statement was of their child's behaviour over the last six months using the responses (0) Not True, (1) Somewhat True and (2) Certainly True. Items were counterbalanced and reverse scored where appropriate. The scale also allows a calculation of the child's total difficulties by summing the scores from each scale except the prosocial scale. The resultant scores can range from 0 to 40.

Participants also filled out a Client Defined Problem and Goal Form (CPG) before and after the sixweek course, which was developed for the purposes of Parents Plus (PP) research. This was used to ascertain the parents' present concerning problem with their child's behaviour and their goal for attending the course. They rated one problem and one goal on a scale from one to ten before the group started. They rated the same problem and goal on a scale from one to ten after the group ended.

In addition, a Weekly Session Rating Form (WSRF) was developed and piloted, for the purposes of this study. In designing the WSRF (see table 3), five questions regarding group processes were selected that from previous groups, clinical practice and the research literature (Assay

& Lambert, 1999; Lambert, 1992) were indicative of positive change, such as how understood and supported parents felt in the group and how hopeful they felt about progress at the end of the group session. Only five items could be selected given the need for the questionnaire to be brief and completed in under a minute at the end of the group session and we attempted to pick questions that matched the processes identified in effective individual therapy by the ISTC (Sharry 2007). Parents were asked to rate the items at the end of each group on a five point Likert scale from (1) strongly disagree to (5) strongly agree. In addition, parents were asked on the WSRF to make brief qualitative comments on what they found useful in the group that day and whether they would have liked anything different.

Although neither the CPG nor the WSRF are validated as yet, we have found these measures to be useful indicators in clinical practice.

## Design

A repeated measures design was adopted to identify any significant changes in behaviour or goal attainment following the PTCC. Paired samples T-tests were conducted to assess any differences in the CPG, SDQ, or any of its' subscales before and after the course. Cohen's *d* was calculated to measure effect sizes.

Spearman's Rho analyses were then conducted to determine if there were any correlations between ratings on the WSRF and participants' outcomes. Trends of satisfaction were also looked at to determine if non-completers reported lower satisfaction with group processes, as anticipated.

## Procedure

The Programmes took place in four schools and one community family centre and were facilitated by Home School Liaison teachers and Child Care Workers who received two days facilitator training. Three groups had two facilitators and two groups had one facilitator and each course involved 6-10 parents.

The facilitators administered the assessments measuring the childrens' strengths and difficulties and the parent defined problems and goals at the beginning and at the end of the course. The weekly session rating forms (WSRF) were completed after each session of the group.

## Results

### *Parent training in community - outcome study*

The Statistical Package for Social Sciences (SPSS, V14) was used to analyse all data. There was a total of forty child participants in the study (22 boys, 14 girls and four unknown). The age range was from one to 11 years with a mean age of 5.23 (SD = 2.21). 38 mothers and two fathers attended the course. 30 parents (75%) completed the six week course, and 29 had complete data to draw from, on which the analyses were run..The children of these parents included; 19 boys, nine girls and one unknown and they ranged in age from one to nine years with a mean age of 5.07 (SD = 2.19). Out of this group, 13 children (45%) had SDQ scores in the clinical or borderline range before the group began. There was a dropout rate of 25% and one set of data was incomplete leaving data from 29 participants to draw on. The means and standard deviations for each variable, along with the results of the statistical analyses can be seen in Table 1.



**Table 1.**

|                         | Time 1            | Time 2           | Sig.  | <i>d</i> |
|-------------------------|-------------------|------------------|-------|----------|
| SDQ Total Difficulties  | 12.97 (SD = 6.48) | 9.62 (SD = 4.26) | .001* | .61      |
| Conduct Problems        | 3.21 (SD = 2.5)   | 2.31 (SD = 1.42) | .024* | .44      |
| Emotional Symptoms      | 2.83 (SD = 2.47)  | 2.24 (SD = 1.79) | .054  | .27      |
| Hyperactivity           | 4.48 (SD = 2.61)  | 2.9 (SD = 2.06)  | .000* | .67      |
| Peer Problems           | 2.45 (SD = 1.99)  | 2.17 (SD = 1.61) | .106  | .15      |
| Prosocial Behaviour     | 7.59 (SD = 2.01)  | 7.76 (SD = 1.77) | .315  | -.08     |
| Client-defined problems | 5.58 (SD = 2.16)  | 2.58 (SD = 1.47) | .000* | 1.62     |
| Client-defined goals    | 3.82 (SD = 1.88)  | 7.45 (SD = 1.50) | .000* | 2.13     |

\* =  $p < .05$ ; Note: All significance scores are one-tailed.

**Table 2.** Borderline and Clinical Scorers on SDQ

|                        | Time 1            | Time 2            | Sig.  | <i>d</i> |
|------------------------|-------------------|-------------------|-------|----------|
| SDQ Total Difficulties | 18.44 (SD = 4.28) | 12.28 (SD = 3.08) | .000* | 1.65     |
| Conduct Problems       | 4.7 (SD = 2.58)   | 2.61 (SD = 1.45)  | .002* | 0.99     |
| Emotional Symptoms     | 4.68 (SD = 2.12)  | 3.26 (SD = 1.61)  | .011* | 0.75     |
| Hyperactivity          | 5.06 (SD = 2.48)  | 3.32 (SD = 2.05)  | .005* | 0.76     |
| Peer Problems          | 3.99 (SD = 1.33)  | 3.09 (SD = 1.61)  | .002* | 0.61     |
| Prosocial Behaviour    | 7.09 (SD = 2.03)  | 8.03 (SD = 1.94)  | .017* | 0.47     |
| Severity of problem    | 6.24 (SD = 1.7)   | 2.76 (SD = 1.16)  | .000* | 2.40     |
| Closeness to goals     | 3.64 (SD = 1.22)  | 7.12 (SD = 1.73)  | .000* | 2.32     |

\* =  $p < .05$ ; Note: All significance scores are one-tailed.

As can be seen, there were significant differences seen in Total SDQ scores, Hyperactivity and Conduct Problems subscales of the SDQ, and in Client Defined Problems and Goals for the group as a whole, with moderate to large effect sizes.

13 of the 29 (45%) parents reported their children to have SDQ Total Difficulties scores in the clinical or borderline range before the group began. This is equivalent to the level of behavioural problems that are typically present in clinical samples, for example, 43% in clinical studies of the Parents Plus Programmes (Quinn et al., 2007). The tests were repeated on this subgroup to get an idea of the potential effects of PTCC as a prevention measure for clinical cases in the community. All outcomes were significant and had moderate to large effect sizes as can be seen in Table 2.

Interestingly and of note, this subgroup benefited on even more subscales than the group as a whole with moderate to very strong effect sizes suggesting the effectiveness for this group in particular.

### *Parent training in community-linking process to outcome*

The second part of this study set out to see if there was a link between process variables and client outcomes. The scores for each of the items on the WSRF were averaged across the six sessions for each participant resulting in a mean score for each of the five items for every participant. Then the changes in participants' scores from before and after the programme were calculated for each construct. The average score for each item on the WSRF and the difference in scores for each construct



**Table 3.** Items on the WSRF

- 
1. I feel I have made progress towards my goals for the course
  2. I feel the group is helpful to me
  3. I feel understood and supported in the group
  4. I feel the group is well organised by the facilitators
  5. I feel hopeful about progress at the end of the group
- 

**Table 4.** Correlations between items on WSRF and outcome measures

| Item | Client Defined Problems | Client Defined Goals | SDQ Total |
|------|-------------------------|----------------------|-----------|
| 1    | .039*                   | .214                 | .356      |
| 2    | .057                    | .391                 | .124      |
| 3    | .079                    | .383                 | .245      |
| 4    | .010*                   | .156                 | .283      |
| 5    | .002*                   | .073                 | .122      |

\* = correlation is significant at .05 level, (one-tailed).

**Table 5.** Correlations between items on WSRF and outcome measures for clinical/borderline group

| Item | Client Defined Problems | Client Defined Goals | SDQ Total |
|------|-------------------------|----------------------|-----------|
| 1    | .226                    | .172                 | .075      |
| 2    | .366                    | .428                 | .059      |
| 3    | .225                    | .422                 | .055      |
| 4    | .252                    | .389                 | .061      |
| 5    | .083                    | .293                 | .013*     |

\* = correlation is significant at .05 level, (one-tailed).

were then analysed using Spearman's Rho analyses to determine if any correlations did exist between item ratings and client outcome. In addition, these analyses were subsequently conducted on the sub-group of participants that had scored in the clinical or borderline range pre-programme. The items of the WSRF can be seen in Table 3.

A significant relationship was found between certain items on the WSRF and changes on the CPG for the group as a whole. Specifically, changes in Client Defined Problem ratings were significantly related to scores on item 1 ( $\sigma = .376$ ,  $p = .039$ ), item 4 ( $\sigma = .481$ ,  $p = .010$ ), and item 5 ( $\sigma = .566$ ,  $p = .002$ ), with trends towards significance reported on items 2 and 3—see Table 4 for full results.

Results from the Spearman's analyses conducted solely on the sub-group of participants that had scored in the clinical or borderline range pre-intervention revealed that the change in their Total Difficulties, as measured by the SDQ, was significantly related to parent scores on item 5 ( $\sigma = .615$ ,  $p = .013$ ) with trends reported on items 1,2,3 and 4), though this was conducted with a limited sample size. See Table 5 for full results.

Finally, using the WSRF forms for the sessions they attended we compared the average scores of the parents who had dropped out of the study to those who completed the group. Though there were low numbers ( $n=10$ ), and the results should be interpreted cautiously there is a trend for items 1, 3, 4, and 5, and overall mean satisfaction, with people who dropped out showing lower scores.

## Discussion

### *Parent training in community*

This research evaluated a pilot study of the Parents Together Community Course which is a shortened preventative version of the Parents Plus Early Years Programme. This study provides evidence that there are high levels of child behavioural difficulties in community samples of parents who refer themselves to parenting groups. In fact, 45% of the parents in the study reported child behavioural difficulties in the borderline or clinical range. This is an alarming percentage which appears more consistent with rates of children attending CAMHS. This shows the need for widespread community-based interventions that aid parents in tackling behaviour problems and promoting positive relationships between themselves and their children. It could be proposed that these parents, whose children are scoring in the clinical range, should have been referred to a more intense group or for therapy on a one-to-one basis in a clinical setting, however, often long waiting lists in clinical settings mean such difficulties may not be addressed right away and it was thought better to proceed with the preventative course in the hopes that an improvement could be sought sooner rather than later. In addition, these families could be referred to more specialist services if their problems remained significant after the initial group.

In Ireland waiting lists for Child and Adolescent Mental Health Services can currently vary between six weeks and three years in different parts of the country (Holmes, 2008). This is a serious situation as the behaviour of children that are not seen promptly may worsen, leaving them at risk for long-term consequences and their parents at risk of stress and anxiety problems. The results from this study are promising in this regard as they show that preventative parenting courses, delivered over a short space of time, with a small amount of training for frontline staff, can effectively reduce behavioural problems, particularly those rated more severely, thus decreasing the likelihood of referral to Child Mental Health Services, and possible subsequent mental health difficulties and social costs. This highlights the importance of early and accessible community delivery of parenting groups and family support to assist parents in managing childhood behavioural problems.

It appears that a two-day facilitator training course can equip professionals in the community to deliver the programme effectively with significant improvements for those attending. This shows that with a small amount of training and resources, communities can benefit greatly from frontline interventions. The accessibility of these courses would be increased for parents in the community thus possibly avoiding the stigma some parents feel is attached to attending CAMHS (Bradby et al., 2007), the risk of children in these communities developing later deviant behaviour would be reduced, and CAMHS would be more accessible for those that need them the most. Pressure would also be relieved from mental health care professionals and government health officials who are frequently criticised regarding inaccessibility of health services.

### *Linking process to outcome*

The second part of this study aimed to see if simple rating scales such as the WSRF can help us identify any process factors which are associated with beneficial outcomes in the PTCC and possibly other group interventions. It appears that certain items on the WSRF are associated with client outcome to an extent. The findings highlight the importance of outlining parents' goals at the start of the course, which is common practice in all Parents Plus programmes, as it appears that if parents feel they are reaching their goals, the identified problems with their child's behaviour will diminish. Significant changes were seen in both clinical and non-clinical groups in those that felt hopeful

about progress at the end of the group on weekly ratings, albeit on different outcome measures. This emphasises the importance of participant beliefs and harnessing hope in group interventions as per previous research findings (Barbic, Krupa & Armstrong, 2009; Tol, et al., 2008). It also highlights the need to focus on the topics that address the specific problems and goals reported by a particular group, so that parents can feel hopeful each week that they are making progress. It is possible that these ratings could work as indicators as to whether or not a parent is going to benefit from the course and appropriate steps could be taken where responses are not indicative of satisfaction. However, these findings are interpreted with caution due to the preliminary nature of the measure, the fact that these associations were linked with different outcome measures for the clinical and sub-clinical group, and the small sample size. These suppositions will need to be confirmed using a larger sample size, perhaps in future community-based parenting courses, and validity analyses are required before conclusions about the utility of the WSRF can be established.

25% of parents dropped out of the course at various stages, which is a higher rate than in previous PPEY studies. Unfortunately, feedback as to why parents dropped out was not available in this research context though it could be due to the fact that it was a community study and little inter-session contact was made with parents by the facilitators. Although there is no specific outcome data for those that dropped out of the course, there was a trend in the data whereby those that did leave appeared less satisfied according to the WSRF. As a result, it is possible that the WSRF could act as an early warning system for clinicians to identify clients that are struggling or unhappy with the PTCC intervention early on and to take supportive action to prevent them dropping out or better tailor services by providing them with alternative interventions. In addition, it could help to reduce drop out rates producing increased results and places would be utilised to their maximum potential. Although this conclusion is speculative, the trend is very interesting and future larger scale studies could determine the effectiveness of the WSRF in this regard.

This technique could be applied to other Parent's Plus groups such as the Parents Plus Children's Programme (PPCP) and the Parents Plus Adolescent Programme (PPAP) in addition to different interventions across the board. The WSRF could act as a process variable that identifies the potentiality or not of an intervention.

The WSRF could also help to identify problem areas in the delivery of the course and suggestions for improvement, week to week within the group, rather than waiting until the end of the course when qualitative feedback is generally obtained. This would benefit the needs of a specific group of parents, in ensuring the intervention could be tailored to their individual needs on a week by week basis.

## **Limitations**

Some limitations of the study include the lack of control group. This could mean that the positive changes seen and decreases in problematic behaviour are merely due to the passing of time or other external factors. Perhaps this could be looked at in future community-based studies whereby parents who self-refer could be put on a waiting list and assessed over the same time period as those attending the course. However, ethical issues do arise with wait-list designs as the parents that are chosen may reap substantial benefits whilst the situation of those on the wait-list may deteriorate and leave them feeling demoralised. Also there are some criticisms of such Randomised Controlled Trials (RCT's) as, although they are seen as the gold standard in treatment efficacy, they do not reflect the reality of day-to-day clinical practice in that most clients do not have a single problem or disorder and they take no account of individual variability in psychopathology (Fortin et al., 2006; Westen, Novotny & Thomas-Brenner, 2004).

There is also a relatively small sample size which means results cannot necessarily be generalised and the sample was quite heterogeneous in age. Usually the PPEY includes parents of children aged one–seven, however the present intervention included parents of children up to age 11 due to the demand for the course in the community setting from these parents and parents were not pre-screened nor was exclusion criteria employed. Larger scale community-based studies using homogenous samples should be conducted in the future to assess if these benefits are corroborated.

In addition, only two fathers attended the programme. There is a need for future studies to explore the reasons for non-attendance by fathers and to put in place measures to recruit fathers, perhaps by putting the courses on at more accessible times for those that may be out to work during the day.

Due to the need for a brief measure, the WSRF contained only a small sample of potential process variables that could mediate group outcome and there are many others such as the number of sessions completed, the function of within session activities such as role-play and practice, and extra-session activities, such as homework completion. In future studies, factor analyses could be employed to develop a standardized tool that links process to outcome for parenting groups for a wide range of variables. In addition, neither the WSRF nor the Client defined problem and goal form have been assessed for validity so only tentative conclusions can be drawn about their utility in a study such as this. A validity analysis should ideally be carried out on these and other measures of process and change if more definitive conclusions are to be drawn.

Though the results were encouraging, the present study only used two outcome measures, however, and future studies could use supplementary standardized measures to explore additional possible benefits of the Parents Together Community Course. In addition as the CPG and the WSRF were not standardized measures, it is difficult to draw more general or normative conclusions.

Despite these limitations the study shows that a preventative parenting course such as this, over a shorter form, can have significant effects on child problem behaviours lessening the need for Child and Adolescent Mental Health Services, albeit within a small sample size. It also shows the possible utility of a process measure in identifying parents that are benefitting from group interventions and those that are having difficulties. This could result in lower dropout rates and increased economy of facilitator time given an appropriate validated process measure.

Although this study supports the fact that parenting techniques appear to be an optimal mode of primary intervention (Campbell et al., 2004; Donner & Klar, 2000; Sanson et al., 1991), future studies could compare the use of the PTCC alongside another alternate intervention based in the community. This would help to determine if the benefits found in this study are due to treatment specific factors or extra-therapeutic factors. The use of a validated process measure would further aid this process and a predictive model of analysis could be used, such as a regression design, to determine if such process factors can predict client outcome. Larger sample sizes and matched participants would also help to generalize findings to the wider population. However, this does not account for the possibility that changes may be seen in problem behaviours over time, regardless of mode of intervention. To remedy this, an RCT could be carried out. Although RCT's do not necessarily reflect the reality of clinical practice and there are ethical concerns around allocating certain people to a waiting list and not others, this would provide the scientific evidence-base that many funding and management agencies require.

## Notes

- i. The Parents Together course was developed by the Parents Plus Charity in collaboration with the Early Learning Initiative, in the National College of Ireland. The research study was jointly funded by the two agencies but was carried out by independent facilitators and an independent research assistant.

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