Early Intervention Music Therapy: Reporting on a 3-Year Project To Address Needs with At-Risk Families

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ABSTRACT: Sing & Grow began in July 2001 as a Playgroup Queensland initiative with the initial 2-year funding period extended by 12 months. Funding is provided by the Australian Government Department of Family, Community Services & Indigenous Affairs. This paper provides a description of the project development, the intervention used, and a summary of achievements during this initial 3-year period.

Sing & Grow is an early intervention music therapy project presented to families with additional needs or those at risk of experiencing disadvantage due to social and/or economic circumstances that may impact their parenting experiences. The aim of the project is to provide short-term music therapy programs to families in communities where access to such services may be limited. The program is strengths-based and focuses on building upon parents’ capacity to relate to and respond to their child’s emotional and developmental needs. Sing & Grow sessions provide an early intervention and prevention service for families with children aged 3 years and under. Music therapy interventions are used to strengthen parent-child relationships through increasing developmentally conducive interactions, by assisting parents to bond with their children, and by extending the repertory of parenting skills in relating to their child through interactive play. This benefits the participants by engaging young children in developmentally stimulating activities while reinforcing to parents the importance of their active participation in assisting their children to meet developmental milestones, emphasizing the importance of early attachment and parent-child relationships in the first three years of life.

Families at Risk

The quality of family life is fundamental to the well being of children (Sanders et al, 1999). Family relationships lay the foundation for individual physical, social, emotional, cognitive, language, and moral development (Sanders, 1995; Sanders & Duncan, 1995). The personal, social, and economic resources of the family unit affect opportunities for individual health, well-being, and development (Edgar, 1992 cited in Sanders, 1995). Therefore, it is important to ensure that a child’s early life experiences include provision for a loving, safe, and supportive environment as well as an environment in which the capacity for attachment and close bonding between parent and child is available and realized (Carr, 2001; Stern, 1985).

Families identified as at-risk of marginalization may experience circumstances that impact their ability to bond and interact with their children (Kelly, Buehlmam, & Caldwell, 2000; Morton & Brown, 1998), and this may have a direct impact on a child’s mental health and well being. In developed countries, up to one in six people aged between 4 and 15 years have clinically significant mental health problems (Sawyer et al., 2000). Early life circumstances have been linked to the development of childhood mental health problems. In particular, parents’ behavior towards their children may play a role in placing children at risk of mental health problems. Lack of parental warmth and affection, and angry, irritable interactions have been identified as contributing to the onset of early emotional and behavioral problems and the later development of conduct problems and depression (Sanders, Gooley, & Nicholson, 2000; NHMRC, 1997). These parenting behaviors are known to occur more frequently in families characterized by parental depression, single parent status, young parenthood, and poor socioeconomic circumstances (Sanders et al., 2000).

The parenting behaviors that place children at risk for mental health problems have been shown to be amenable to change with positive effects on children’s behavioral and emotional functioning. Evidence is strongest for psychologist-delivered behavioral parenting interventions based on social learning models (Sanders et al., 2000; Kazdin, 1991; Patterson, 1982). Parenting programs delivered in nonpsychology service sectors for the parents of children who have not yet developed clinical levels of disorder have revealed some positive outcomes (Turner & Sanders, 2006; Zubrick et al., 2005) in intensive interventions that were as brief as three to four sessions (Turner & Sanders, 2006). However, positive results have not been found universally (Bower et al., 2001). Only 19% of parents access parenting interventions (Sanders et al., 2000), and around half of those who commence a program fail to attend more than half of the planned sessions (Barrera et al., 2002; Harachi, Catalano, & Hawkins, 1997).

Thus the dissemination of effective preventive interventions to parents of young children who are at risk of developing mental health problems remains one of the most significant challenges faced by those who try to improve the mental health of the population (Turner & Sanders, 2006). The reach...
of these programs has, in part, been limited by reluctance on the part of community service providers to adopt behavioral parenting programs (Taylor & Biglan, 1998). While the reasons for this remain unclear, anecdotal reports received during discussions with staff from community-based family support organizations highlight concerns about the highly structured and directive nature of such interventions and a perceived lack of cultural fit with the needs of diverse disadvantaged client populations. There is a need to consider alternate programs which take account of the services in which parents are willing to engage and the intervention approaches that community organizations are comfortable in promoting to their clients.

**Music & Music Therapy Programs**

Music-based parenting interventions, including music therapy programs, have the advantages of providing a non-threatening environment in which to promote and reinforce appropriate parenting while providing enjoyable experiences for both parents and children. When offered in a group setting co-located with other community services, these programs may also offer opportunities to develop mutually supportive relationships between parent participants (Mackenzie & Hamlett, 2005) and to establish links between parents and other service providers. Anecdotal evidence, including program waitlists and qualitative feedback from participating families and referring staff, suggest that these approaches may be more acceptable to parents, in particular, those who agencies find difficult to engage when offering more highly structured, behaviorally-based parenting interventions.

Music has long been associated with parent-child interactions and bonding. The act of singing is one of the earliest and most common forms of musical interaction shared between a parent and child (Papousek, 1996; Oldfield, 1995). Music used with families in an interactive way within a group setting can support participants in developing skills that enhance parent-child relationships (Abad & Edwards, 2004; Abad, 2002; Oldfield & Bunce, 2001; Oldfield, 1999; Vlismas & Bowes, 1999; Shoemark, 1996; Oldfield, 1995).

**Music Therapy and Parent-Child Programs**

Music therapy work with parents and children to help prevent issues that may arise from social disadvantage is an emerging clinical area (Abad & Edwards, 2004; Oldfield & Bunce, 2001). While there is some literature pertaining to parent-child programs in music therapy and related fields, the area is generally under reported and researched. Music has been used to enhance relaxation during labor and childbirth (Brown, 2001), to reduce isolation and increase interactions in family centered social work groups (Lyons, 2000), to address depressed mood states in adolescent mothers (Field, 1998), to nurture confidence and creativity in mothers of children with developmental delays (Shoemark, 1996), to address cultural needs (Williams & Abad, 2005), and as a preventative strategy with 'well' families (Mackenzie & Hamlett, 2005).

A mother and toddler music therapy group that aimed to help families experiencing difficulties with parenting was reported by Oldfield & Bunce (2001). The program provided opportunities for the parents to interact with their children in developmentally conducive and spontaneous ways and helped to recreate a warm, bonding interaction between the mother and her child (no fathers attended). Many of the mothers had not experienced good parenting themselves, and so music therapy sessions also supported them in rediscovering their ability to play and have fun with their children through music making.

**Sing & Grow**

The *Sing & Grow* music therapy project is designed as an early intervention for high risk parents of infants and young children (0–3 years). *Sing & Grow* programs are 10 week, group interventions delivered by qualified music therapists, where music and song are used as non-threatening, enjoyable media for engaging with parents and young children. Interactive music-based activities are employed as a means for the following: encouraging parents to connect with and take pleasure from their children; teaching parents specific skills for fostering their children's behavioral, social, and communication skills; promoting positive parenting behaviors; and enhancing parents' sense of parenting competence and mental health. Specific parenting strategies that are modeled include the following: the use of praise and positive reinforcement; nonverbal communication through eye contact, smiling, and physical affection; direct teaching through modeling and hand-over-hand facilitation of gross and fine motor skills; the use of simple verbal instructions; setting boundaries for children; and using music and song for engaging, soothing, or calming children.

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The program teaches parents activities that extend children’s behavioral, social, and communication skills and demonstrates how repetition and practice enhances developmental competence. To aid in the transfer of activities to the home environment, participants are provided with a CD and songbook. *Sing & Grow* is also designed to increase participants’ contacts with other service providers, and both formal and informal referrals are provided to families when needs are identified.

**Establishment**

*Sing & Grow* began in 2001 following a successful funding application (by Dr Jane Edwards & Brandy Walker, University
of Queensland) written in response to a call from the Australian federal government for new initiatives to promote family well being. The Playgroup Association of Queensland partnered the application, went on to bursar the grant, and remains the bursar and key supporter of Sing & Grow. The vision of the founding director of the project (first author of this article) was to provide an early intervention and prevention service for parents who were experiencing circumstances that impacted their ability to parent. It was hoped that a program using music therapy techniques and principles would provide a non-threatening and supportive environment to engage and encourage such families to access services to build their parenting skills and bond with the children. Two years initial funding was provided with a 3rd year extension granted. When the extension was granted, the second author became acting director for the duration of the 3rd year. To date, both authors continue in national management roles following the national expansion of the project in 2004. The first 6 months of the funding cycle focused on two key areas: developing resources and developing community networks, followed by a trial program and the commencement of clinical services in community settings across South East Queensland.

Developing Resources

Resources for the project predominately included the creation of the Sing & Grow “kit” which comprised many colorful and high-quality musical instruments and props; the development of materials for use in the programs, including the collation of traditional and original song material; and the development of the CD resource to be given to each participating family. The CD contains 20 children’s songs used in the Sing & Grow program, including well-known nursery songs, action and movement songs such as Twinkle, Twinkle Little Star, and a number of original songs written by Australian music therapists. These songs were specifically composed to address concept comprehension skills, listening skills, body part awareness, movement activities, and other developmental tasks. Quiet lullaby songs were placed at the end of the CD to encourage parents and children to sit together and share a quiet time. These songs may also be used to help children sleep or relax. The musical resources were developed by the founding director by researching what songs were popular with young Australian children, what material was frequently used by music therapists, and by sourcing or writing repertoire that best addressed the emotional and developmental needs of the clients presenting to the program.

Documentation protocols were also established that would capture information from the programs that could be reported back to the funding body. Goals and objectives for the project were established in accordance with the anticipated needs of the families, and documented and recorded in line with ongoing funding requirements.

A session plan was established to promote quality and consistency in program delivery in relation to the target goals while being flexible enough to respond to the needs of individual and diverse families. The session was designed to be fun, non-threatening, and welcoming. Musical activities that are engaging and nurturing and allow for quality family interactions were incorporated in each section of the session. Specifically, face-to-face interactions, hand-over-hand facilitation, and coactive use of instruments were planned to increase interactions and play during sessions. It was planned that modeling, peer learning, and facilitated learning were to be the key methods used in working with families in the group environment.

The funding body required collection of data including number of people attending, age of parents and children, and marital status of participants. In addition, pre and post parent questionnaires provided insight about the perception of the participants regarding whether the program had helped them to learn ways to interact and play with their children through music that could be transferred into the home environment. Descriptive observation forms were also designed for the music therapists to make notes each week on interactions between dyads observed and child developmental changes observed during each 10-week program. The above data served as a pilot which allowed for modification before programs were initiated.

Developing Community Networks

Community networks were established through intensive community in-servicing and through accessing and building upon the existing community networks of which Playgroup Queensland was a part. Local government authority statistics were used to locate geographic regions where the residents were deemed to be at higher risk of marginalization or isolation. This included indicators such as welfare recipiency, unemployment, marital status, ethnic and Indigenous status. Agencies within these communities were then sent a brochure advertising a first round of information sessions that were held in community halls in four key geographic locations and conducted in partnership with Playgroup Queensland. These then lead to requests for intensive in-house in-services for a number of community agencies who supported at risk families. Child-health clinics that supported families with new babies in the identified regions were also targeted.

During this initial period, 20 in-services were conducted throughout South East Queensland. Attending these sessions were approximately 120 staff and volunteers from community organizations that supported young parents, young women in crisis, women who have experienced domestic violence, parents and children with disabilities, Indigenous families, families from non-English speaking cultures, and low income families. It was important that strong links be established in the community with organizations that could make referrals to the program and provide ongoing support to the families who participated.

Service Provision

Trial

The funding agreement for Sing & Grow stipulated that 20 programs were to be conducted each year in the community,
Initially, one trial program was conducted at a community centre that supported a diverse range of families, including those at risk of marginalization. On completion, the session plan, goals, and objectives were modified to better represent the needs of the families but still meet the needs of funding requirements, and documentation and evaluation protocols were established.

During the trial, it became evident that parents would need to be actively encouraged to sit on the floor in circle formation, and participate in each section of the session. Parents also had to be encouraged to have their child sit on their lap during the sessions. During the trial, many parents were observed to place the children on the floor and then leave the room to have a cigarette and talk to other parents. Some parents would prefer to stand or sit in chairs at the back of the room to watch their children rather than sit with their children. There was also a need to explain clearly to the collaborating organisation that Sing & Grow was not a “music group” for children but rather a parent-child program, and hence the active inclusion of the parent. Workers from referring community organisations were recruited to model interactive behaviors by actively participating in the session and encouraging parents to remain with their child throughout sessions.

Sessions would generally follow the planned structured format that would include a hello song, action and nursery songs, movement songs and games, instrumental play, quiet music, and then a goodbye song. The structure of the session was based upon the founding director’s experience working with young children, trial and error of order of activities that would engage children and their parents over a period of time, and discussions with other music therapists working in early childhood or early intervention settings.

Community Programs

A total of 20 Sing & Grow programs were conducted each year in the community sector. Sessions were conducted by the director (8 per year), or a qualified music therapist who was contracted to Sing & Grow as a session leader (12 programs per year). A total of eight session leaders were trained to conduct programs over the 3 year period.

Results

Sing & Grow was funded as an early intervention program for families in South East Queensland. Outcomes of the program during the first three years are based on data collected and collated from pre and post parent surveys, clinical observations from the session leaders, feedback from collaborating organizations and families, and project administration records. The funding of this program did not include any scope for a research design, formal evaluation procedures, or in-depth data analysis.

Sixty-three programs were completed with 683 families referred. Data indicated that the programs were successful in reaching a variety of client groups: Approximately 35% of participants were single parents; 30% were young parents; 25% were low SES; 15% had a parent or child with a disability; 12% were from a family with a history of domestic violence or abuse; 12% were referred with parenting or attachment problems; and 6% were from Indigenous or non-English speaking backgrounds.

The findings further indicated that programs were successful in attracting parents, with 93% of those referred attending at least one session. Ongoing participation rates were more modest, with 54% attending at least half of the sessions offered. Research indicates that drop out rates for parent training programs often range from 6-44% (participants who begin programs but do not complete) (Barlow & Coren, 2004), and so Sing & Grow attrition rates may be comparable with findings from other preventive parenting programs (Barrera et al., 2002; Charlebois, Vitaro, Normandeau, & Rondeau, 2001).

Reports from parents who completed end-of-program questionnaires also revealed high levels of parent satisfaction (100% enjoyment; 94% would like to participate again); a positive perception of the program’s impact on parent-child relationships (70% reported feeling closer to their child); and a translation of activities to the home setting (87% used music for behavior management purposes at home) (Williams & Abad, 2004). These categories were designed by the directors to gauge parent satisfaction in the program and their perception of whether they had learned new skills that could be transferred to the home environment.

Observations documented by the music therapists indicated that the program was a useful treatment intervention for increasing parent-child interactions and cofacilitated play experiences. Attending children were observed to generally participate more frequently and actively in activities that encouraged cognitive, physical, and social development over the course of each program conducted. Such results are demonstrated by the following case vignettes.

Jamie

In a Sing & Grow program run with Indigenous families one toddler, Jamie, presented as a highly energetic child. He was unable to sit for any period of time and seemed unaware of his peers in the group. Jamie spent most sessions resisting his mother’s efforts to contain her “naughty” boy, yelling out, running around the room and out of the group. The session leader used verbal encouragement, modeling, positive reinforcement, scaffolding of tasks, and encouragement of Jamie’s mother’s attempts to engage him. A marked improvement was noted over the course of the 10 week program. Initially, not willing to participate in fine or gross motor activities during sessions, Jamie began to join in with at least two activities in each session by session 6 and more than three activities in each session by session 8. These activities included completing actions songs, playing small percussion instruments, dancing with ribbons and in partnership with his mother, and using the therapy balls. Jamie also demonstrated improved skills in hand-eye coordination over the course of the program when using the drums, shakers, bells, castanets and a rain stick.

1 Not his real name.
also gained strength in the area of concept comprehension and by the end of the program had demonstrated knowledge of: up/down, loud/soft, fast/slow, start/stop and identifying body parts. Jamie showed marked improvements in his ability to attend to all activities by the end of the program. During session 2, he wandered around the room unless specific activities that were highly motivating to him were being conducted. However, by the end of the program, Jamie remained seated for the entire 50–60 minute session, including the hello and goodbye songs. At the beginning of the program, Jamie responded to greeting songs by frowning and ignoring the session leader and the group but began to respond with smiling and eye contact by the end of the program. He was also initially resistant to sharing and turn-taking but became more and more confident with these social interactions with both his peers and the session leader, and by the end of the program, he was initiating swapping instruments in the group.

An Indigenous elder attended this program and continued to support the group following the end of 10 weeks of Sing & Grow. When interviewed she said the following about Jamie and his mother:

When he first came he would just come in, not look at anybody, didn’t want to join in any activities. He wasn’t interested in the instruments or the therapist—he kept running away all the time, wasn’t interested, just wanted to do his own thing. After a couple of weeks he gradually came back in and he would sit—and still run off—but he would always come back and sit. He eventually sat for whole sessions and participated, listened and became very interested. Ever since Sing & Grow has finished he participates quite well now in any activities like sitting, painting, listening. His participation has greatly improved since Sing & Grow so he’ll be really well equipped to start preschool. Sing & Grow has really helped his readiness for school. His Mum wasn’t really confident in doing activities with her child either, but after a couple of weeks she gained more confidence because he was sitting more. It helped her with her parenting skills—helped her and her child engage more together—has helped tremendously. Mum was really impressed and proud when others made comments about her son’s achievements as well. She found that very rewarding (Playgroup Queensland, 2005).

Margaret

Margaret was referred to a Sing & Grow program to assist with perceived difficulties in playing with her children and her feelings of anger and resentment, evident in her communications with her children. The session leader and referring social worker also observed signs of depression. The program was conducted with a support group for women who had survived domestic violence and/or experienced attachment issues with their children. Margaret attended 7 of the 10 sessions offered with her two young children.

During the first session Margaret appeared uncomfortable interacting with her children and remained very quiet and passive throughout the group. However, during session 4, she was observed to interact with her children for the first time, consisting them in completing action songs and engaging in partner songs such as Row Row Your Boat. Margaret had spent some time away from her children during the previous week and expressed having missed them for the “first time in her life.” Levels of interaction continued to improve throughout the remainder of the program as the session leader provided positive feedback to Margaret on her attempts to engage her children and provided a musical holding environment in which the family felt safe to explore intimate interactions which were not a usual part of their repertoire.

During the final session, Margaret was observed to hug her children and rock with them during quiet music. This was the first time she had been observed to interact in a gentle and nurturing way during the 10 week program. Margaret also appeared more relaxed and happy and was observed to use increased levels of positive reinforcement with her children. This coincided with increased participation and verbal interaction observed in her youngest child. Upon completion of the program, Margaret reported that she had found the program “fun” and would like to attend another program.

Discussion

The findings of the first three years of Sing & Grow service delivery are consistent with previous evaluations of music and music therapy programs as an early childhood parenting intervention for first-time mothers (Vlismas & Bowes, 1999), parents of infants with developmental delay (Shoemark, 1996), multi-ethnic or highly disadvantaged parents (Oldfield, Adams, & Bunce, 2003; Oldfield & Bunce, 2001; Lyons, 2000; Field, 1998), and “well” families (Mackenzie & Hamlett, 2005). These authors have reported that early childhood music therapy and music program interventions can result in increased parenting satisfaction (Oldfield & Bunce, 2001); high levels of parent and child engagement (Oldfield et al., 2003; Lyons, 2000); increased positive parent-child interactions and child social and developmental skills across sessions (Lyons, 2000); parents’ improved understanding and enjoyment of their children (Oldfield et al., 2003; Vlismas & Bowes, 1999; Shoemark, 1996); a greater use of music and song activities at home (Vlismas & Bowes, 1999; Shoemark, 1996); and increased feelings of social support (Mackenzie & Hamlett, 2005).

The use of music by parents to encourage their children to grow and learn is not new. The use of music therapy to assist parents to extend their repertoire of successful and nurturing parental behaviors in interaction with their young children is however, relatively new (Abad & Edwards, 2004). What is unique about Sing & Grow is its capacity to harness the support and, therefore, resources of the Australian federal government to underpin the development of a wide ranging project that has now been funded (to $2.5 million) to be delivered throughout Australia. The Sing & Grow initiative is now the farthest reaching music therapy project in Australia and represents one of the largest groups of music therapists working together in this country.

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An action research framework has allowed project staff to constantly reflect, analyze, and improve service delivery. Recommendations for further development based on learning experiences from the project are as follows:

First, it is recommended to continue the use of qualified music therapists for project management and program service delivery. Australian music therapists have undergone specialized tertiary training in the use of music to meet therapeutic goals of people with special needs. The success of the project in achieving outcomes for families through short-term group therapy can be directly related to the professional skills of the music therapists facilitating programs. While community musicians and music teachers are able to conduct group music sessions, they are often not trained to assess and identify needs, make clinical observations and measure outcomes, liaise and communicate with other health professionals, and counsel families in crisis.

Second, it is recommended to expand the project across Australia. Sing & Grow is the first project of its kind providing quality short term group music therapy to at risk parents and their children. Given the flexible and adaptable nature of the program structure, few major modifications were envisioned in order to implement expansion. In January 2005, the Australian Federal Government committed an extra $1.7 million funding to support the national expansion of Sing & Grow, which will be reported in future articles.

Third, it is recommended to revise evaluative procedures. The project staff is committed to contribute to the Australian early intervention evidence base, and hence, some reviewing and revising of evaluative processes has been conducted to ensure that data suitable for rigorous research analysis are collected. The evaluation protocol used for the first 3 years was effective in capturing anecdotal evidence and feedback from the participants that identified their perception of programs, but the protocol did not effectively capture change in parenting patterns, interactions, and relationships. New evaluation protocol that is sensitive to the needs of at-risk families but reliable and valid has since been developed, trialed, and implemented in collaboration with a contracted external evaluation team. Results will be reported in future papers.

Conclusion

Sing & Grow is an innovative early intervention music therapy project that has thus far been accessed by 635 Queensland families. This initiative has provided 832 children and their parents with the opportunity to benefit from a short term, no cost and creative early intervention service. The data collected to date, as described earlier, indicate that parent inter-active and play skills can be improved through participation in Sing & Grow programs with the support of community organizations and Playgroup Queensland. Programs have been observed to have influenced family interactions, demonstrated through enhanced musical play, communication skills, and general “togetherness. Sing & Grow programs have been an effective intervention strategy for working with families who are at risk of marginalization as the environment for intervention is non-threatening and is presented outside of the welfare model, focusing and building on family strengths rather than deficits. Changes to evaluation protocol and increased funding and personnel support for research purposes will allow for more thorough and rigorous measures of the impact of Sing & Grow on parental behavior, interactions, and family relationships, and the effectiveness of the project in community networking and social capacity building.

Sing & Grow is highly valued within the community sector as an effective short term early intervention program for families. The project received a National Highly Commended Child Protection Award in 2003, from the Australian Council for Children and Parenting. Furthermore, publicity via media, primarily in the print media in the form of newsworthy stories and case studies; 57 community organization in-services and presentations; 12 national and international conference presentations, and three published articles has helped to raise the profile of music therapy in Australia and to educate the wider community of the need for specialized early intervention services for Australian families.

Sing & Grow continues to provide quality experiences and professional services to people within the community who are most at need of support. Families now have access to an excellent and free resource to promote the learning and maintenance of new skills through group participation. Participation helps to strengthen families and community networks and supports the most important people in our communities—children.

References


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