

**Family Matters: Positive Parenting Reduces Adolescent Substance Use and
Adverse Childhood Experiences**

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Abstract

Substance use among adolescents is incessantly problematic, but its recent collision with a rising opioid epidemic has exponentiated deaths in this age group. Despite opioids being a major contributor, indications remain that adolescent prevention efforts should focus on total substance abstinence. Evidence consistently highlights adverse childhood experiences and mental dysfunction as the strongest predictors of youth substance use initiation, and parent-focused interventions as the most significant prevention model. Participants in this project included five parents, with a teen between 11 and 16 years of age, who had recently experienced homelessness or where currently living in a transitional shelter. Guided by the Transtheoretical Model, this project assessed the impact of an evidence-based parenting program among high-risk families. Participants completed the Teen Triple P Online program from home while receiving weekly text message support. Each parent completed a pre-and post- Conflict Behavior Questionnaire ($r=.86$) and Depression, Anxiety, and Stress Scale ($r =.71-.81$), and a Client Satisfaction Questionnaire. A two-tailed Wilcoxon signed rank test was performed on the matched pairs of pre- and post-measures with the mean scores compared. Though statistically insignificant results were yielded, this quality improvement project found a clinically significant decrease in conflict behavior and parental anxiety, depression, and stress after completing the Teen Triple P Online program. Participant satisfaction with the program and subsequent family improvements was also found. These results suggest that interventions that decrease family conflict and improve a parent's mental health, directly impact major family factors that contribute to adolescent substance use and adverse childhood experiences. This project contributes to the evidence that positive parenting programs have an impact at the individual, family, and societal levels.

Keywords: substance use, opioids, adolescent, parenting education, prevention, homeless

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Research has well established that the recreational use of tobacco, alcohol, opioids, and illicit drugs contributes to poor health outcomes and early mortality. In 1998, the Centers for Disease Control and Prevention and Kaiser Permanente advanced prevention awareness to new heights when reporting their findings. In the first large-scale study of its kind, researchers found a significant association between adverse childhood experiences (ACEs) and the development of chronic disease, substance abuse, and homelessness later in life (Felitti et al., 1998). Though the definition of ACEs is not arbitrary, it can vary between sources and studies. The most referenced adversities a child may experience are emotional, physical, and sexual abuse; physical or emotional neglect; and household dysfunctions involving caregivers (after this, referred to as parent or parents), such as violence between parents, separation, divorce, parental substance abuse, parental mental illness, or an incarcerated parent (Houtepen et al., 2020). According to McLellan (2017) and the National Institute on Drug Abuse (NIDA, 2014), the correlation is strong between ACEs and substance use, contributing to negative outcomes such as individual homelessness, delinquency, mental health struggles, and high-risk behaviors.

The ACEs report has become a landmark study that has led researchers to investigate ways to decrease and prevent childhood trauma (Felitti et al., 1998). Critical findings have confirmed the hypothesis that dependency and addiction often start in adolescence, are directly connected to ACEs exposure, and have a lifetime impact on adulthood trajectory. With this information exposed, major organizations such as the Substance Abuse and Mental Health Services Administration, the World Health Organization, and the Centers for Disease Control

and Prevention, all have initiatives aimed at reducing and preventing teen substance use, and focus specifically on childhood adversities that are strong contributing factors.

Background and Significance

Problem Statement

According to Hudgins et al. (2019), substance use, specifically prescription opioid abuse, has become a leading cause of unintentional injury and death among adolescents. They also found that adolescents with opioid misuse were significantly more likely to use other substances and illicit drugs (Hudgins et al., 2019). Since the original ACEs study, a substantial body of new research correlates a myriad of adverse behavioral and emotional outcomes to childhood maltreatment, family history of mental health disorders, and parental substance use (Braciszewski et al., 2018; Gabrielli et al., 2016; McLellan, 2017; NIDA, 2014; Siegel et al., 2016; Winstanley & Stover, 2019). These types of actions by parents contribute to a child's ACEs. Thus, they are a serious global public health problem because of their impact on physical health conditions such as ischemic heart disease, cancer, chronic lung disease, and mental health conditions like anxiety, depression, and addiction.

Purpose and Rationale

All youth are considered vulnerable to substance use, but risk factors for early opioid initiation, injection drug use, and the likelihood of experiencing overdose increases as ACE exposure increases (Centers for Disease Control and Prevention [CDC], 2020; Winstanley & Stover, 2019). Further compounding the issue is that teens are more susceptible to developing a substance use disorder (SUD) than adults due to their underdeveloped and malleable brains, thus making any substance use problematic during the teen years (McLellan, 2017; NIDA, 2014). Multiple studies indicate that more than 85% of those who meet the criteria for a SUD at some

point in their lifetime also met the requirements during adolescence (McLellan, 2017; NIDA, 2014). Despite the current knowledge surrounding the detrimental effects of teen substance and opioid misuse, prevention data is sparse and less consistent among adolescents, and even more so among high-risk adolescents exposed to multiple ACEs (Hudgins et al., 2019). This project aims to explore evidence-based prevention strategies for adolescent substance use, specifically focusing on teens at an increased risk for ACEs.

Epidemiological Data

Substantial increases in multi-substance and opioid-related emergency room visits, hospital and intensive care stays, and deaths rates have been trending upwards for the last 20 years with little relief (Hudgins et al., 2019; NIDA, 2014; Trust for American's Health, 2020). An article by the American Academy of Child and Adolescent Psychiatry (2018) reported that first alcohol use often starts before age 12 and the average age of marijuana use is 14. According to the U.S. Department of Health and Human Services (HHS, 2021), in 2017, alcohol or illicit drug use in the past 30 days among adolescents aged 12–17 years was 13.8%. The National Center for Drug Abuse Statistics (2022) reports that 50% of all teenagers have misused a drug at least once, 62% of 12th grade students have abused alcohol, and between 2016 and 2020, there was a 61% increase in drug use among 8th graders. Furthermore, Inman et al. (2020) highlight how, on an average day, an estimated 881,684 American adolescents smoke cigarettes, 646,702 use cannabis, and 457,672 consume alcohol. Unfortunately, the adverse effects of the COVID-19 pandemic have only increased many of those statistics. The heightening of such numbers can be explained by the substantial base of evidence that suggest ACEs have a dose-type response, meaning adolescents who endure four or more ACEs are two to five times more likely to engage

in personal substance use and other high-risk behaviors (Felitti et al., 1998; National Health Care for the Homeless Council [NHCHC], 2019).

Internal Evidence

A large urban homeless shelter that provides support services for families while aiding in permanent re-homing found a gap in their services. The facility has recognized that the COVID-19 pandemic has increased the stressors of their resident population and that ACEs such as parent-child conflict and parental substance abuse have increased on the campus. The facility already works with families to address the various issues that led to their housing instability but have not focused on the adolescent population at high risk for substance use. The shelter has also been slow to address current substance use, and mental health issues caused by COVID-19.

Youth in these families face multiple ACEs that increase their risk of developing a SUD, including parental SUD, parental mental illness, poverty, violence, family conflicts, domestic violence, and trauma (Ijadi-Maghoodi, 2019; NHCHC, 2019). Bannon et al. (2012) found that youth in shelters who used two to three substances concurrently were almost five times more likely to have low levels of parent-child communication, parental monitoring, and family support than youth in shelters who did not use substances. Many studies also report alcohol and drug use in 66-97% of youth experiencing housing instability and homelessness, noting that these rates significantly exceed matched samples of securely housed adolescents (Lightfoot et al., 2018). Thus, the use of substances in these adolescents appears to center around the ACEs endured before or during homelessness and low family engagement and support (Bannon et al., 2012). This evidence and the accompanying statistics have created a desire among the shelter's leadership to address the underlying reasons for teen substance use and assist their families in preventing substance use among their teens.

PICO Question

Preliminary interest in the identified problem led to an inquiry into current evidence to determine the best interventions for substance use prevention among teens experiencing homelessness with their families. These findings supported the development of a clinically relevant PICO question; “Among adolescents who have experienced family homelessness, how does childhood adversity coping education compare to substance use education in reducing illicit substance initiation and misuse?”

Evidence Synthesis**Search Strategy**

An exhaustive review of current literature was completed using the following databases: PubMed, Cumulative Index of Nursing and Allied Health Literature (CINAHL), and PsycINFO. All databases were chosen for their high standards and scientific rigor related to medical and nursing research and evidenced based practice in healthcare. Keywords included *adolescents, youth, teens, drug use, substance use, opioid use, family homelessness, housing instability, residential instability, adverse childhood experiences, childhood trauma, prevention, education, guidance, intervention*. Boolean operators were used in all databases with a five-year inclusion criterion. PubMed was further filtered to only include randomized controlled trials (RCTs), systematic reviews, and meta-analyses; CINAHL was filtered to only include peer reviewed articles; and PsycInfo was filtered to only include peer reviewed, quantitative, and qualitative studies.

Studies were excluded if they exclusively focused on homeless (street-involved) youth, foster youth, or adult populations. Studies were also excluded if they were culturally tailored or in a language other than English. Remaining studies were evaluated for relevance to this projects

topic, then the hierarchy, quality, and strength of articles was assessed. Ten studies were selected and analyzed for homogeneous variables and interventions.

Foundation of Research & Evidence of Clinical Issue

While substance use prevention is well-studied in the literature, opioid misuse prevention is scarcely examined as a single substance, and data on adolescent prevention is lacking. Likewise, adolescent homelessness is frequently explored, but typically in the context of living alone on the streets. Consequently, there is a paucity of data related to substance and opioid misuse prevention in adolescents experiencing homelessness with their families. Due to these limitations, research on this at-risk population must use general adolescent substance use prevention as the best evidence.

This systematic process brought several essential factors to light concerning adolescents and substance misuse: (a) ACEs and poor mental health are the strongest predictors of substance use initiation; (b) substance use, but particularly opioid misuse, is of distinct concern during adolescent brain development; (c) prevention efforts in teens should focus on total substance abstinence, not merely opioid misuse prevention; (d) improvement in family function is significantly more effective than substance use education given directly to adolescents; and (e) family-focused interventions (parent-child communication, parental monitoring, and family support) that strengthen protective family factors and child resilience show the most significant effect (Bannon et al., 2012; Chatterjee et al., 2019; Cotton, 2016; Fowler & Schoeny, 2017; Hudgins et al., 2019; Ijadi-Maghsoodi et al., 2019).

Evidence Influence on DNP Project

Coping behavior such as smoking, drinking, and using drugs are often a way to deal with the trauma of ACEs (Felitti et al., 1998). Evidence shows that children living in poverty are more

likely to carry high ACE numbers, and children living below the Federal Poverty Line (FPL) are five times more likely to experience greater than four ACEs than those who live in financially stable households (Halfon et al., 2017).

Much research has identified parenting education as the best way to recognize and address childhood trauma or prevent it from happening in the first place, thus avoiding the risk factors linked to teen substance use (CDC, 2020; NHCHC, 2019). Research-based parenting programs can significantly boost protective factors, improve resilience, and eliminate or reduce risk factors for adolescents substance use among any socioeconomic group (NIDA, 2020).

Project Foundation

The evidence is strong that improving family dynamics is significantly more effective than providing education directly to parents or teens about the impact of ACEs or the dangers of substance use. Likewise, the reoccurring theme that family-focused interventions had the most significant effect in preventing adolescent substance initiation was impactful. Synthesis of the evidence laid the foundation for bringing a parenting and family support program to the family shelter.

While investigating possible evidence-based parenting programs, considerations included cost, sustainability, health literacy, and COVID-19 conditions affecting implementation. The Triple P program was selected because it was found to already be implemented statewide under the state-initiated Opioid Action Plan and had funding available through the State Opioid Response grant (Governor's Office of Youth, Faith and Family, n.d.). Triple P is a multilevel, multidisciplinary program that is supported by more than 35 years of ongoing research in over 830 trials, studies, and published papers (Triple P, n.d.). Triple P is also used in more than 30 countries, translated into 22 languages, and has been shown to work across cultures, socio-

economic groups, and in many different family structures (Triple P, n.d.). In fact, in 2009, the United Nations Office on Drugs and Crime (UNODC) regarded Triple P as the number one family skills program in the world based on the scientific evidence and randomized control trials completed showing positive results (UNODC, 2009). By teaching parents the skills found in Triple P (n.d.), they are able to raise confident, healthy children and teenagers, build stronger family relationships, manage misbehavior, and prevent child-rearing problems from occurring. The Triple P program chosen for implementation was the Teen Triple P Online (TTPO) which takes the evidence-based and empirically supported information from Triple P and translates it into a web-based, self-directed, teen specific adaptation with similar efficacy and validity of the original program (Triple P, n.d.).

Theoretical Framework

When looking at the vulnerable population of adolescents who have experienced homelessness with their families, it is their parents that have the most impact on whether substance use will be prevented or reduced. The Transtheoretical Model (TTM) developed by Prochaska and DiClemente (1982) is also known as the Stages of Change Model and is a well-established theoretical framework that operates on the assumption that people do not change behaviors quickly and decisively, but rather, people are at different stages of readiness to adopt healthful behaviors (Butts and Rich, 2018). The TTM focuses on an individual's decision to change and the six stages they will likely experience: (a) precontemplation, (b) contemplation, (c) determination, (d) action, (e) relapse, and (f) maintenance (see Appendix A, Figure A1).

The purpose of using this framework is to create opportunities for parents to engage and assimilate information regardless of their stage. TTPO is available to parents for an additional 10 months after the implementation period ends, thus providing opportunities for re-engagement

when advancing into a new stage. Progressing through these stages of change requires the application of cognitive, affective, and evaluative processes that are subject to both internal and external influences. With such variability in personal experiences and readiness, the cyclic and fluid model for change created by the TTM, harbors a more forgiving measure of success than a linear model allows.

Implementation Framework

The Iowa Model of Evidence-Based Practice to Promote Quality Care was initially published in 1994 as a research utilization tool but expanded in 2001 to include utilization of evidence (Reavy, 2016; Titler et al., 2001). As a framework for evidence implementation, this model appears more complicated than linear frameworks, but its extensive application and clarity is practical as it considers an organization's patients, providers, and infrastructure during the project planning stage (Reavy, 2016). The Iowa Model is comprised of a series of pathways that start with identifying a focused trigger and then proceeding with forming a team, assembling research and literature, critique and synthesis of research, implementing a practice change, and monitoring and analyzing the change. Along these pathways, three critical decision points help guide the process (see Appendix A, Figure A2). The Iowa Model is well-suited for this project as the decision points allow process modifications depending on research findings and organizational needs.

Methods

Subject Protection

To protect subjects in this project, the procedures and protocols were submitted to the ASU Internal Review Board (IRB) for approval. Prior to implementation, an expedited approval was received November 24th, 2021. Ethical considerations and implementation included gaining

informed consent, voluntary participation, no participant coercion, early withdrawal without penalty, participant confidentiality, and deidentifying data during analysis.

Population and Setting

Improving family dynamics and relationships starts with the parent(s), thus project participants were parent(s) of at least one teen between the ages of 10 and 16 years old who have or are experiencing homelessness with their children. English speaking with online access was required. To avoid unaccounted bias on the measured outcomes, individuals could not be participating in any other parenting programs simultaneously.

Participants were recruited from an urban family homeless shelter that houses 150 families at a time, up to 450 families a year, who stay up to 120 days before being permanently housed. Additional participants came from a 48 unit, low-income, subsidized permanent housing apartment complex, owned, and operated by the family homeless shelter. Both locations offer employment services, a computer lab with internet, and life-skills classes, both during and after transition. Initial contact with potential participants was made using a secure Zoom meeting for parents in the family homeless shelter, or in-person at the apartment complex's community center. Subsequent TTPO participation was completed by parents on their electronic devices, whether at home or in a computer lab.

Project Description and Timeline

The TTPO is a teen targeted positive parenting program delivered exclusively online. Initial in-person contact with potential participants was used to explain the project purpose, share information about ACEs, educate on TTPO, and ultimately build a bridge of knowledge on how parenting impacts ACEs and teen substance use. Participants worked independently through six interactive modules, each taking 30 to 60 minutes to complete, and completing at a pace of one

module per week. A weekly raffle was available to anyone completing a new module, and a final raffle was available to anyone completing all six modules. The project timeline was as follows:

1. Following IRB approval on Nov 24th, 2021, recruitment flyers were distributed around both facilities beginning December 10, 2021, and continued until the program commenced on January 11, 2022. Potential participants signed up for the initial informational event via a QR code provided on the flyers.
2. The informational event was held on January 11, 2022, at the apartment complex community center and via Zoom for the homeless shelter participants due to COVID-19 restrictions. Consents and measurement instruments were collected in-person or through a secure email, then access to TTPO was provided to each uncoerced participant.
3. Participants were encouraged to complete one module a week so they would have time to practice new principles between modules. Pacing was ultimately up to each individual.
4. Check-ins were completed weekly by the project facilitator through email and/or text message to offer support and encouragement, assist in staying on track for a six-week program completion, and to notify weekly raffle winners. Support of weekly check-ins is based off the findings by Day and Sanders (2018) that report a significant correlation between the number of direct consultations and number of TTOL modules completed by participants.
5. The implementation period concluded February 22, 2022, and post- intervention measurement instruments and a satisfaction questionnaire were distributed electronically via email to all participants that completed any number of modules.

Budget and Funding

There were no direct costs associated with this project. Individual TTPO accounts are \$79.95 each when purchased independently, but participants' access to TTPO for this project were provided at no cost from Prevent Child Abuse Arizona (PCAAZ). PCAAZ is a nonprofit child advocacy organization who is the largest recipient of grant funding from the State Opioid Response grant. These grant funds have been strategically distributed to organizations equipped to address the multiple components of Arizona's opioid epidemic. PCAAZ has chosen to use a portion of their grant funds to expand Triple P programs in Arizona.

Most data collection was done electronically with only a few documents requiring printing. Direct compensation for participating was not part of this project, but to encourage engagement, raffle prizes were given away weekly and at project conclusion. The family shelter provided prizes using existing donations of gift cards and a laptop.

Measurement Tools, Data Collection, and Data Analysis

A TTPO Demographic Questionnaire was used at baseline to collect key demographic information, indicators of socioeconomic status, and risk profile (see Appendix B, Figure B1). Two pre- and post- intervention measurement tools were used to assess TTPO impact; the Conflict Behavior Questionnaire (CBQ) (Robin & Foster, 1989) and the Depression, Anxiety, and Stress Scale (DASS-21) (Lovibond & Lovibond, 1995). Client satisfaction was assessed using the Client Satisfaction Questionnaire (CSQ) (Sanders et al., 2012) at post-intervention.

Parental perception of conflict with teen was measured using the CBQ, which is a 20-item true or false scale of parents' perceived behaviors of their teen over the last two weeks (see Appendix B, Figure B2). Results yield a single score that ranges between 0-20 with scores of 12.4 (+/- 5.0) being representative of distressed parents experiencing conflict with their

adolescent. The 20 question CBQ has internal consistency of ($\alpha = .90$) and a correlation coefficient of $r = .96$ to the original, full CBQ.

Parental adjustment was measured using the DASS-21 to assess symptoms of depression, anxiety, and stress in parents as those symptoms are primary risk factors for child maltreatment and neglect (see Appendix B, Figure B3). Measured on a Likert type scale of 0–3, each of the 21 questions are connected to one of the three subscales, and each subscale score can range between 0–42. Depression scores of 14 or higher, anxiety scores of 20 or higher, and stress scores of 34 or higher are all clinically significant. The DASS-21 demonstrates internal consistency for all subscales (Depression, $\alpha = .91$; Anxiety, $\alpha = .79$; Stress, $\alpha = .89$) and a test–retest reliability ($r = .79 - .91$) (Day & Sanders, 2018).

The CSQ is a 13-item measure commonly used within Triple P research to assess satisfaction in the service received, whether the program has met the family needs, and whether the program equipped them to deal with problems effectively (see Appendix B, Figure B4). Items are rated on a scale of 1 to 7 and are summed to attain a total score ranging between 13 and 91, with higher scores correlating with greater satisfaction.

The demographic questionnaire, CBQ, and DASS-21 were initially collected during the introduction event or electronically via email and a CBQ, DASS-21, and CSQ were collected electronically via email after six weeks of the TTPO program. The surveys and questionnaires were anonymous using a unique participation ID which allowed for identification of corresponding of pre- and post- material. Electrotonic and digital means of contact and data collection included Zoom, SignUpGenius, SurveyMonkey, and secure email and text messaging.

Data analysis was completed using Intellectus Statistics (2021). Descriptive statistics provided information on variables of demographic significance and a two-tailed Wilcoxon

signed rank test was used to examine whether the mean differences of the pre- and post- TTPO instruments were significantly different for each matched pair.

Results

Five participants agreed to participate, and descriptive statistics were used to analyze the demographic information provided. As seen in Table 1, of the five ($n=5$) participants, the average age was 33.60 years ($SD = 4.51$, $Min = 30.00$, $Max = 39.00$) and their adolescents' had an average age of 12.80 ($SD = 1.92$, $Min = 11.00$, $Max = 16.00$).

Table 1

Summary Statistics Table for Participants' Ages

Variable	<i>n</i>	<i>M</i>	<i>SD</i>	Min	Max
Parent Age	5	33.60	4.51	30.00	39.00
Teen Age	5	12.80	1.92	11.00	16.00

Table 2 shows that four ($n = 4$, 80%) parents were female and one ($n = 1$, 20%) parent was male, while three ($n = 3$, 60%) adolescents were male and two ($n = 2$, 40%) were female. Three ($n = 3$, 60%) parents identified as white while one ($n = 1$, 20%) identified as multiracial and one ($n = 1$, 20%) identified as black. Two ($n = 2$, 40%) parents had current or prior involvement in a Department of Child Safety (DCS) case, three ($n = 3$, 60%) parents' children had current or prior exposure to domestic violence, and one ($n = 1$, 20%) parent's child had a parent currently or priorly incarcerated. All ($n = 5$, 100%) parents had experienced homelessness with their children but three ($n = 3$, 60%) were currently homeless with their children, living in the transitional shelter. All participants ($n = 5$, 100%) were currently using AHCCCS services. Of the five participants who completed the initial requirements, four started the TTPO program and two participants completed all six modules, the CSQ, and the post- CBQ and DASS-21.

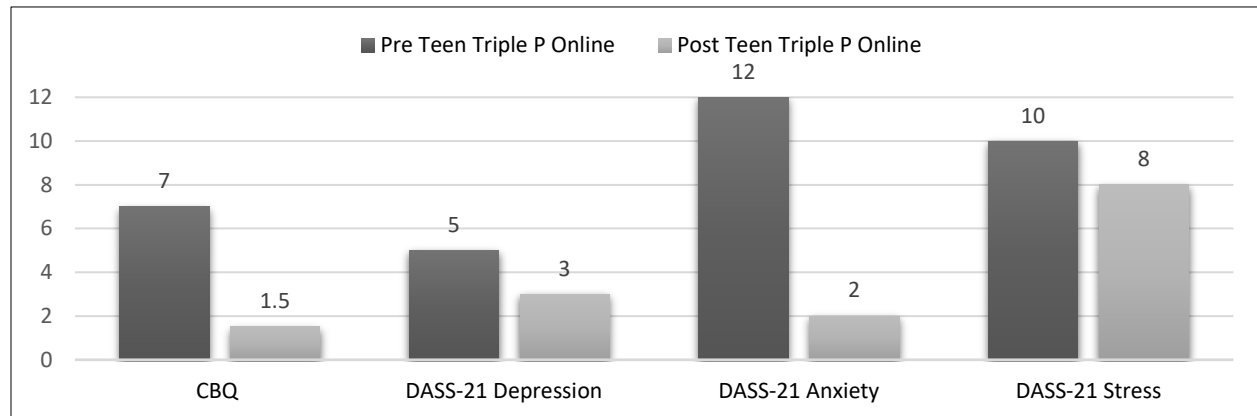
Table 2*Frequency & Percentage Table for Demographic Variables*

Variable	<i>n</i>	%
Parent Gender		
Male	1	20.00
Female	4	80.00
Parent Age		
30	2	40.00
31	1	20.00
38	1	20.00
39	1	20.00
Parent Ethnicity		
White	3	60.00
Multi-racial	1	20.00
Black	1	20.00
Teen Gender		
Male	3	60.00
Female	2	40.00
Teen Age		
11	1	20.00
12	2	40.00
13	1	20.00
16	1	20.00
DCS Involvement (Current or Prior)		
Yes	2	40.00
No	3	60.00
Teen Witness to Domestic Violence (Current or Prior)		
Yes	3	60.00
No	2	40.00
Incarceration of Teen's Parent (Current or Prior)		
Yes	1	20.00
No	4	80.00
Homelessness (Current or Prior)		
Yes	5	100.00
No	0	00.00
AHCCCS Services (Current)		
Yes	5	100.00
No	0	00.00

For those participants who completed the post- CBQ and DASS-21 ($n=2$), Figure 1 shows that the mean scores of the pre- and post- CBQ and DASS-21 subscales had a decrease in the negative behaviors and emotions experienced by the participants.

Figure 1

Mean Scores of CBQ and DASS-21 Pre- and Post- Teen Triple P Online



Results of a statistical analysis using a two-tailed Wilcoxon signed rank test on the matched pairs of pre- and post- CBQ and DASS-21 subscales for full participant ($n=2$) are seen in Table 3. Findings show the CBQ pre-intervention ($M = 7.00$) and CBQ post-intervention ($M = 1.50$) were not significantly different based on an alpha value of .05, $V = 3.00$, $z = -1.34$, $p = .180$. The DASS-21 depression subscale pre-intervention ($M = 5.00$) and DASS-21 depression subscale post-intervention ($M = 3.00$) were not significantly different based on an alpha value of .05, $V = 1.00$, $z = -1.00$, $p = .317$. The DASS-21 anxiety subscale pre-intervention ($M = 12.00$) and the DASS-21 anxiety subscale post-intervention ($M = 2.00$) were not significantly different based on an alpha value of .05, $V = 3.00$, $z = -1.34$, $p = .180$. The DASS-21 stress subscale pre-intervention ($M = 10.00$) and DASS-21 stress subscale post-intervention ($M = 8.00$) were not significantly different based on an alpha value of .05, $V = 2.00$, $z = -0.45$,

$p = .655$. All results were non-significant indicating that the differences could be explained by random variation.

Table 3

Change in Parent CBQ and Dass-21 Subscale Scores

Variable	<i>n</i>	Pre <i>M</i>	Post <i>M</i>	<i>α</i>	<i>V</i>	<i>z</i>	<i>p</i>
CBQ	2	7.00	1.50	.05	3.00	-1.34	.180
DASS-21 Depression	2	5.00	3.00	.05	1.00	-1.00	.317
DASS-21 Anxiety	2	12.00	2.00	.06	3.00	-1.34	.180
DASS-21 Stress	2	10.00	8.00	.05	2.00	-0.45	.655

Note. $p > 0.05$. Fail to reject all null hypotheses and will not accept the alternative hypotheses

Significance

While there was a decrease in the negative behaviors and emotions experienced by both participants that shows clinical significance, statistical significance could not be established due to small sample size and high attrition rate.

Project Impact

Participation in this evidence-based parenting program has shown to have direct benefits to participants by decreasing parent-child conflict and decreasing symptoms of depression, anxiety, and stress, which are risk factors for child maltreatment and neglect. The CSQ results had a mean score ($M = 85$) which reflects participant satisfaction with the program and improvements. Likewise, such improvements positively impact overall family function and decrease risk factors for ACEs and subsequent substance use initiation and abuse, regardless of statistical significance lacking.

Sustainability

Statewide implementation of Triple P programs under the Opioid Action Plan creates longevity for the use of TTPO in the family shelter setting. The Governor's Office of Youth,

Faith and Family (n.d.) is combatting the opioid crisis by distributing funds to organizations throughout the state that support and implement substance use prevention strategies. Thus, during project implementation and moving forward, TTPO access has been supplied to the facility for free while grant funding is available. Also, being a self-contained online program means no staff or training is required for future implementation.

Discussion

The literature abounds with evidence that improving parenting skills and family function increases child resiliency and decreases the risk factors for ACEs and adolescent substance use. While this project was not able to establish a statistical significance for implementing a positive parenting program with parents in high-risk families, it did show improvements in family function and program satisfaction. Strengths included the program being evidence-based with proven efficacy, being an online format for convenience, having sustainable potential, and being implementable in families of low socioeconomic status and other high-risk factors. Unfortunately, the small sample size, high attrition rate (60 %), and low post-survey return created limitations to the project.

Future recommendations include implementing in a larger population sample, including longitudinal follow-up of CDB & DASS-21, longitudinal follow-up of substance use in the teens, and assessment of barriers to program participation and completion.

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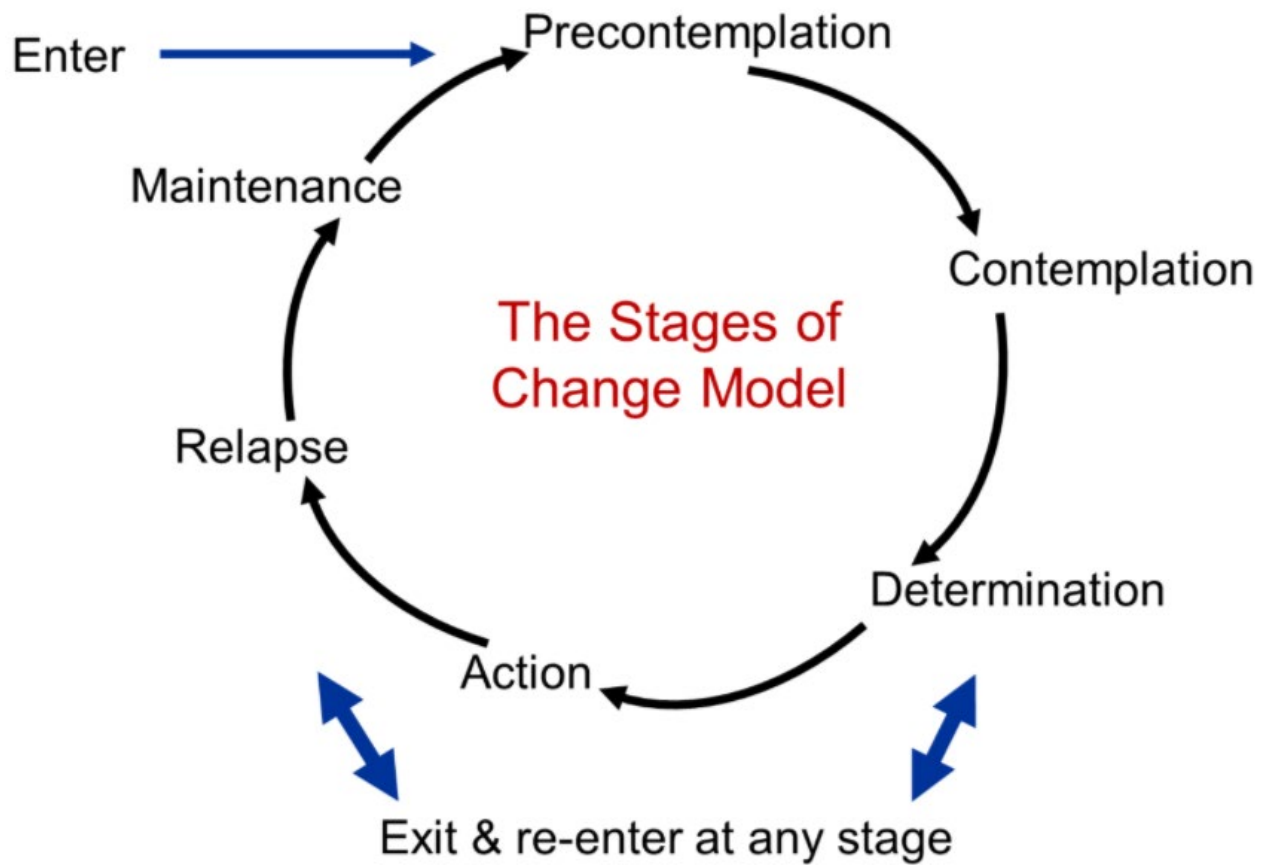
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Appendix A

Models and Frameworks

Figure A1

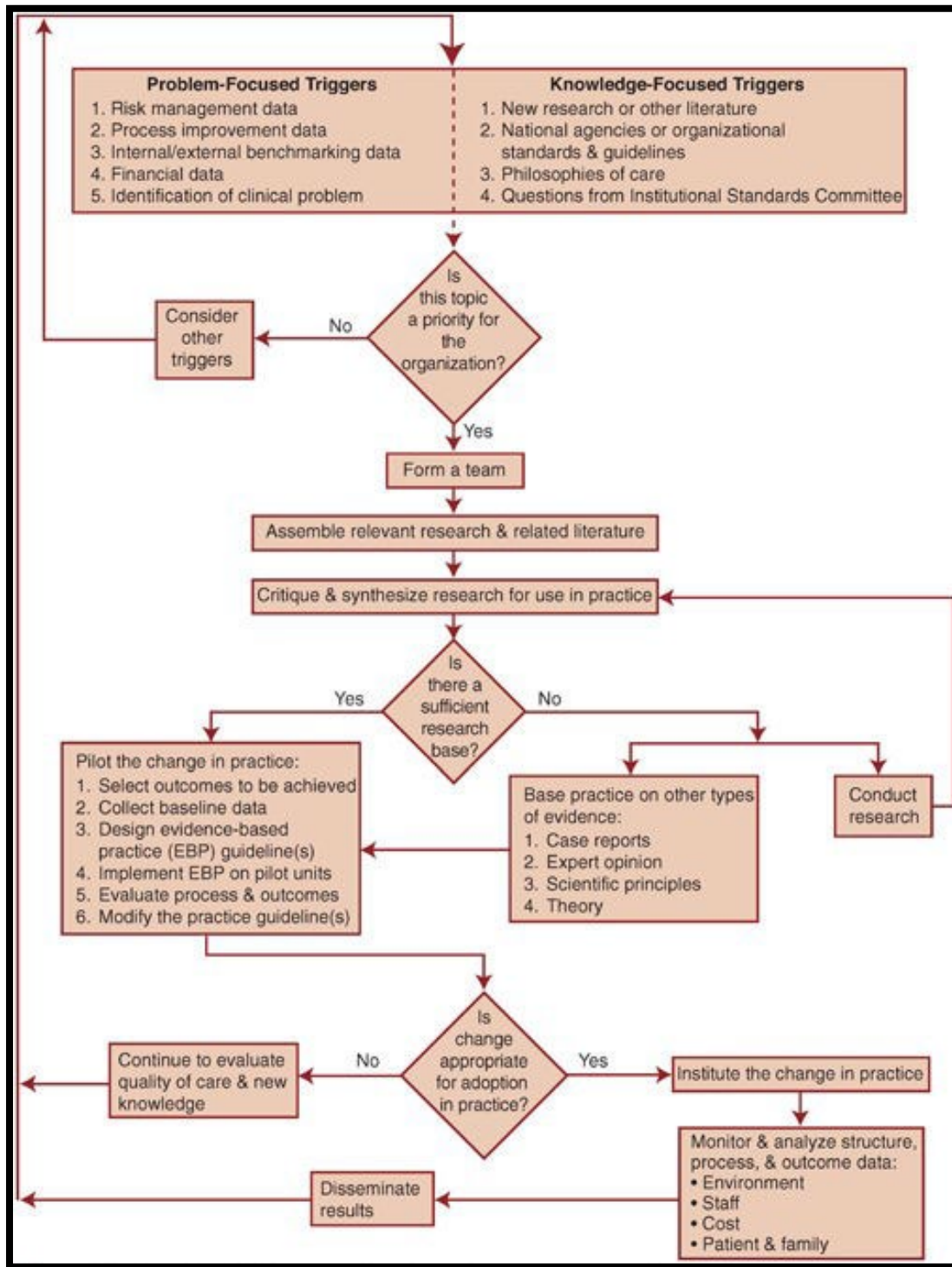
Transtheoretical Model



Note. Prochaska & DiClemente (1982)

Figure A2

The Iowa Model of Evidence-Based Practice to Promote Quality Care



Note. Titler et al. (2001)

Appendix B

Measurement Tools

Figure B1

Demographic Questionnaire



Teen Triple P Data Collection Form



Parent ID		Level 4 Triple P Intervention	<input type="checkbox"/> Std Teen	<input type="checkbox"/> Grp Teen
Teen ID				
Practitioner ID		Date of First Session/Group	____/____/____	

	Parent Demographics	Teen Demographics
Age (whole number)		
Gender	<input type="checkbox"/> Female <input type="checkbox"/> Male	<input type="checkbox"/> Female <input type="checkbox"/> Male
Ethnicity	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Multi-racial <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White (non-Hispanic)	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Multi-racial <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White (non-Hispanic)
Zip Code (5 digit)	AHCCCS? <input type="checkbox"/> Yes <input type="checkbox"/> No	DCS? (current or prior) <input type="checkbox"/> Yes <input type="checkbox"/> No
Parent Incarcerated? (current or prior)	<input type="checkbox"/> Yes <input type="checkbox"/> No	D.V.? (current or prior) <input type="checkbox"/> Yes <input type="checkbox"/> No

Clinical Outcome Measures	Pre- Triple P	Post- Triple P
CBQ Conflict Score – Mother Report for Teen (range 0-20)		
CBQ Conflict Score – Father Report for Teen (range 0-20)		
CBQ Conflict Score – Teen Report for Mother (range 0-20)		
CBQ Conflict Score – Teen Report for Father (range 0-20)		
DASS-21 Depression Scale score (range 0-42)		
DASS-21 Anxiety Scale score (range 0-42)		
DASS-21 Stress Scale score (range 0-42)		

Client Satisfaction Questionnaire Teen (item responses range 1-7)												
Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	Q13

Date of Last Triple P Session/Group	____/____/____
Total # of Level 4 Teen Sessions or Groups	
Language in which Triple P Delivered	<input type="checkbox"/> English <input type="checkbox"/> Spanish
Completed Intended Triple P?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Note. Used at baseline to collect key demographic information and indicators of socioeconomic status. Created by Triple P to be used with the Teen Triple P programs. Reprinted with permission.

Figure B2

Conflict Behavior Questionnaire

Triple P – Positive Parenting Program®



Conflict Behaviour Questionnaire — Parent

You are the teenager's **mother** **father** (check one).
 You are filling this questionnaire out regarding your **son** **daughter**
 (check one), who is **aged** years old.

Think back over the last 2 weeks at home. The statements below have to do with you and your teenager. Read the statement, and then decide if you believe the statement is true. If it is true, tick the box marked true, and if you believe the statement is not true, tick the box marked false. For each item, please tick either true or false, but never both for the same item. Answer for yourself, without talking it over with your partner.

	True	False
1. My teenager is easy to get along with.	<input type="checkbox"/>	<input type="checkbox"/>
2. My teenager is receptive to criticism.	<input type="checkbox"/>	<input type="checkbox"/>
3. My teenager is well behaved in our discussions.	<input type="checkbox"/>	<input type="checkbox"/>
4. For the most part, my teenager likes to talk to me.	<input type="checkbox"/>	<input type="checkbox"/>
5. We almost never seem to agree.	<input type="checkbox"/>	<input type="checkbox"/>
6. My teenager usually listens to what I tell him/her.	<input type="checkbox"/>	<input type="checkbox"/>
7. At least three times a week, we get angry at each other.	<input type="checkbox"/>	<input type="checkbox"/>
8. My teenager says that I have no consideration of his/her feelings.	<input type="checkbox"/>	<input type="checkbox"/>
9. My teenager and I compromise during arguments.	<input type="checkbox"/>	<input type="checkbox"/>
10. My teenager often doesn't do what I ask.	<input type="checkbox"/>	<input type="checkbox"/>
11. The talks we have are frustrating.	<input type="checkbox"/>	<input type="checkbox"/>
12. My teenager often seems angry at me.	<input type="checkbox"/>	<input type="checkbox"/>
13. My teenager acts impatient when I talk.	<input type="checkbox"/>	<input type="checkbox"/>
14. In general, I don't think we get along very well.	<input type="checkbox"/>	<input type="checkbox"/>
15. My teenager almost never understands my side of an argument.	<input type="checkbox"/>	<input type="checkbox"/>
16. My teenager and I have big argument about little things.	<input type="checkbox"/>	<input type="checkbox"/>
17. My teenager is defensive when I talk to him or her.	<input type="checkbox"/>	<input type="checkbox"/>
18. My teenager thinks my opinions don't count.	<input type="checkbox"/>	<input type="checkbox"/>
19. We argue a lot about rules.	<input type="checkbox"/>	<input type="checkbox"/>
20. My teenager tells me s/he thinks I am unfair.	<input type="checkbox"/>	<input type="checkbox"/>

Note. From Robin, A.L. & Foster, S.L. (1989) *Negotiating parent-adolescent conflict: A behavioral-family systems approach*. New York: Guilford Press. Reproduced by Triple P with permission.

Figure B3

Depression, Anxiety, and Stress Scale

DASS₂₁	Name: _____	Date: _____
<p>Please read each statement and circle a number 0, 1, 2 or 3 that indicates how much the statement applied to you <i>over the past week</i>. There are no right or wrong answers. Do not spend too much time on any statement.</p> <p>The rating scale is as follows: <input checked="" type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3</p> <p>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</p>		
1	I found it hard to wind down	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
2	I was aware of dryness of my mouth	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
3	I couldn't seem to experience any positive feeling at all	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
4	I experienced breathing difficulty (eg, excessively rapid breathing, breathlessness in the absence of physical exertion)	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
5	I found it difficult to work up the initiative to do things	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
6	I tended to over-react to situations	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
7	I experienced trembling (eg, in the hands)	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
8	I felt that I was using a lot of nervous energy	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
9	I was worried about situations in which I might panic and make a fool of myself	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
10	I felt that I had nothing to look forward to	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
11	I found myself getting agitated	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
12	I found it difficult to relax	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
13	I felt down-hearted and blue	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
14	I was intolerant of anything that kept me from getting on with what I was doing	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
15	I felt I was close to panic	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
16	I was unable to become enthusiastic about anything	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
17	I felt I wasn't worth much as a person	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
18	I felt that I was rather touchy	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
19	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)	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
20	I felt scared without any good reason	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
21	I felt that life was meaningless	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3

Note. From Lovibond, P. F., & Lovibond, S. H. (1995). The structure of negative emotional states: Comparison of the Depression Anxiety Stress Scales (DASS) with the Beck Depression and Anxiety Inventories. *Behaviour Research and Therapy*, 33(3), 335–343 ([https://doi.org/10.1016/0005-7967\(94\)00075-u](https://doi.org/10.1016/0005-7967(94)00075-u)). In the public domain.

Figure B4

Client Satisfaction Questionnaire

Triple P – Positive Parenting Program®



Client Satisfaction Questionnaire

This questionnaire will help us to evaluate and continually improve the program we offer. We are interested in your *honest opinions* about the services you have received, whether they are positive or negative. Please answer all the questions.

Please circle the response that best describes how you honestly feel.

1. How would you rate the quality of the service you and your teenager received?
 7 6 5 4 3 2 1
 Excellent Good Fair Poor
2. Did you receive the type of help you wanted from the program?
 1 2 3 4 5 6 7
 No, definitely not No, not really Yes, generally Yes, definitely
3. To what extent has the program met your *teenager's* needs?
 7 6 5 4 3 2 1
 Almost all needs Most needs Only a few needs No needs
 have been met have been met have been met have been met
4. To what extent has the program met *your* needs?
 7 6 5 4 3 2 1
 Almost all needs Most needs Only a few needs No needs
 have been met have been met have been met have been met
5. How satisfied were you with the *amount of help* you and your teenager received?
 1 2 3 4 5 6 7
 Quite dissatisfied Dissatisfied Satisfied Very satisfied
6. Has the program helped you to deal more effectively with your teenager's behaviour?
 7 6 5 4 3 2 1
 Yes, it has helped Yes, it has No, it hasn't No, it made
 a great deal helped somewhat helped much things worse
7. Has the program helped you to deal more effectively with problems that arise in your family?
 7 6 5 4 3 2 1
 Yes, it has helped Yes, it has No, it hasn't No, it made
 a great deal helped somewhat helped much things worse
8. Do you think your relationship with your partner has been improved by the program? (leave this item blank if you are a single parent)
 1 2 3 4 5 6 7
 No, definitely not No, not really Yes, generally Yes, definitely
9. In an overall sense, how satisfied are you with the program you and your teenager received?
 7 6 5 4 3 2 1
 Very satisfied Satisfied Dissatisfied Very dissatisfied

10. If you were to seek help again, would you come back to Triple P?

1 2 3 4 5 6 7
No, definitely not No, I don't think so Yes, I think so Yes, definitely

11. Has the program helped you to develop skills that can be applied to other family members?

1 2 3 4 5 6 7
No, definitely not No, I don't think so Yes, I think so Yes, definitely

12. In your opinion, how is your teenager's behaviour at this point?

1 2 3 4 5 6 7
Considerably worse Slightly worse The same Slightly improved Improved Greatly improved

13. How would you describe your feelings at this point about your teenager's progress?

7 6 5 4 3 2 1
Very satisfied Satisfied Slightly satisfied Neutral Slightly dissatisfied Dissatisfied Very dissatisfied

14. Since the beginning of this program, have you sought further assistance for your teenager's behaviour or for your family from any other source? If so, please describe.

.....
.....
.....
.....

15. Have you had any other problems with your teenager which you feel may be related to the original difficulty?

.....
.....
.....

16. Do you have any other comments about this program?

.....
.....
.....

Thank you

Note. From Larsen, D. L., Attkisson, C. C., Hargreaves, W. A., & Nguyen, T. D. (1979). Assessment of client/patient satisfaction: Development of a general scale. *Evaluation and Program Planning*, 2(3):197-207. ([https://doi.org/10.1016/0149-7189\(79\)90094-6](https://doi.org/10.1016/0149-7189(79)90094-6)). Adapted and reproduced with permission by Sanders et al. (2012) for Triple P use.