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A parenting-skills intervention to mitigate adverse childhood experiences for children of parents in substance use disorder recovery.

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A Parenting-Skills Intervention to Mitigate Adverse Childhood Experiences for Children of Parents in Substance Use Disorder Recovery

by

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Abstract

Background: Parents recovering from substance use disorder (SUD) are prone to neurobiological alterations that affect parental emotional regulation, increasing occurrence of harsh parenting, heightened stress, and relapse. Children with parents who suffer from SUD experience adverse childhood experiences (ACE), predisposing them to negative health and lifestyle risks. Implementing a parenting-skills intervention for parents in recovery can promote positive-parenting, reduce parenting stress, improve the parent-child relationship, and mitigate the effects of ACEs.

Setting: ChooseWell Communities (CWC), a sober-living community, in Louisville, KY served as the project site. Participants at CWC are sober parents with primarily young children under 5 years old, who meet weekly on Wednesday night for accountability and to learn techniques to maintain sobriety.

Purpose: This quality improvement project was intended to implement Hope at Home, a parenting-skills curriculum designed for parents with SUD, to decrease parenting stress and improve parent-child relationship to mitigate adverse childhood experiences in their children. This project intended to show that the Hope at Home curriculum could be well received by participants and feasibly and sustainably implemented at CWC.

Procedures: Hope at Home was delivered to participants once a week, for 8-weeks, at CWC during regular weekly meeting sessions. Each session lasted approximately 45-60 minutes.

Measures: Parental stress was measured utilizing the parenting stress index-short form (PSI-SF). Pre- and post-implementation data were compared to analyze the effectiveness of Hope at Home on decreasing parental stress, thus improving parental engagement, bond, and skills (American Psychological Academy [APA], 2011).

Results: There was a statistically significant difference between the pre-PSI-SF and post-PSI-SF at 12-weeks (p=.030). Although not statistically significant, there was a moderately negative correlation between sessions attended and post-8-week PSI-SF total stress scores and post-12-week total stress scores. Paired t-tests comparing male and female participant PSI-SF scores at each phase of data collection did not suggest statistical significance.

Discussion: The parenting skills intervention was well received by participants in which they reported high acceptance and agreeance to feedback regarding programming. Generalizability to practice and implementation in other recovery programs is limited as each program is unique. With improved adherence and consistency in participant engagement, more data would have been available to analyze of the participants. CWC intends to incorporate Hope at Home curriculum into their orientation process consisting of 4 to 6 sessions. Lessons will be taught by a board certified Psychiatric Mental Health Nurse Practitioner (PMHNP).

Keywords: adverse childhood experiences, parents, substance use disorder, hope at home, parental stress

A Parenting-Skills Intervention to Mitigate Adverse Childhood Experiences for Children of Parents in Substance Use Disorder Recovery

Parents recovering from substance use disorders, living in a sober living community, with adverse childhood experience (ACE) scores greater than 6, engage in parenting behaviors that interfere with healthy relationship building with their young children ages 0-5 years. Implementing a parenting-skills program to assist in developing parenting and coping skills, strengthening parent-child relationship through bonding and attachment, and building resilience has been suggested to mitigate the impact of adversities for children of parents with substance use disorders.

Background

Adverse childhood experiences, or ACEs, are traumatic incidents individuals ages 0-18 years may experience that generate a heightened probability of health and lifestyle risks once adults including: depression, chronic illness, early death, and substance misuse and use disorders (American SPCC, n.d.; Centers for Disease Control and Prevention [CDC], 2022). These traumatic events can be quantified and measured via ACE scores. While total ACE scores are not yet standardized, heightened exposure to the adverse events, and thus a higher ACE score, is indicative of increased risk for health morbidities and lifestyle risks including substance use disorder. ACE scores are measured within three domains including abuse, neglect, and household dysfunction and are then subcategorized to make ten total inclusion criteria (American SPCC, n.d.). Each subcategory consists of a ‘yes’ or ‘no’ question, with ‘yes’ equating to ‘1’ and ‘no’ equating to ‘0’. Other underlying contributors to traumatic events in one’s life including poverty, racism, or ethnicity is not measured, therefore the assessment cannot wholistically quantify trauma in individuals (American SPCC, n.d.).

The Centers for Disease Control and Prevention (CDC) conducted the Kaiser ACE Study from 1995 to 1997 with over 17,000 participants to study childhood events and well-being later in life (CDC, 2022). The Kaiser ACE Study was the first to analyze and correlate increased quantity of ACEs to risk of disease development in adulthood, including elevated risk of substance use with correlation to previous childhood abuse and neglect (CDC, 2022). The Stop Abuse Campaign relayed these findings confirming adults with an ACE score of 4 have four-fold increase likelihood of developing alcohol abuse disorder, three-times likelihood of suffering from chronic depression in both genders and double the chance for heart disease and stroke when compared to a person with an ACE score of 0 (Stop Abuse Campaign, n.d.). Increased ACE scores have been directly correlated to five of the top ten leading causes of death including heart disease, diabetes, cancer, suicide, and respiratory disease (CDC, 2019).

In the fiscal year of 2019-2020, Kentucky children ages 0-17 years had experienced at least two ACE qualifying events equating to 16.9% of KY children, which is 2.1% above the U.S. national average (America's Health Rankings, 2021). In Jefferson County, 50% of adults report having at least two ACEs (Kentucky Youth Advocates, 2022a). Bloom Kentucky is an initiative, generated by Kentucky Youth Advocates, devoted to ending adverse childhood experiences within the state by policy changes and budget investments with aspirations to diminish the multigenerational cycle of trauma (Kentucky Youth Advocates, 2022b). Bloom Kentucky also emphasizes the importance of providing safe and supportive environments for children to promote resilience to diminish negative effects of ACEs overtime (Kentucky Youth Advocates, 2021, p. 2). Kentucky Youth Advocates understands the urgency to provide resources for families through various outlets to promote a healthy relationship between parent and child. Reducing the effects of ACE scores could reduce health conditions in adults with a decreased

projection in incidence of depression by 44%, asthma by 24%, stroke by 15%, diabetes by 6% and more (CDC, 2019, p. 2).

One domain measured in ACE scores is household dysfunction, with a subcategory accounting for a child or adult who has a parent who suffered from substance misuse, or a substance use disorder. Of the children in KY who are affected by ACEs, 10.4% are due to disordered substance use in the home (America's Health Rankings, 2021). Substance use is defined as the pattern of compulsive use of legal and prohibited drugs including alcohol and nicotine in which the intent of using is to satisfy the psychological or physical craving (APA, 2022). When there is repetitive use of the substance involving risk taking and affecting daily life through impaired functioning, a person may be diagnosed with substance use disorder (SUD) by a professional (Cataldo et al., 2019; Saxon, 2023). This repeated abuse will alter the brain's function which will incite cravings, abnormal behaviors, emotional dysregulation, and impaired decision making (Saxon, 2023).

When parents, specifically women, repetitively abuse substances, they are more inclined to have uncharacteristic parenting skills and behaviors which will adversely affect interaction between parent and child as well as formed attachment style (Cataldo et al., 2019). There are four overall attachment styles; secure attachment is the only positively defined attachment of the four which promotes resilience and may mitigate the effects of ACEs (CDC, 2019). With influence from hormones such as estradiol and progesterone, women are more apt than men to suffer from explicit effects of substance use which directly influences dopamine receptors; in return motivating cravings and relapse (Cataldo et al., 2019). Nonetheless, both men and women suffer from neurobiological modifications that disrupt neurotransmitters such as dopamine, that impacts mood, attention, and memory, as well as oxytocin, a hormone released when a parent

and child are bonding. Recovery in early parenthood is difficult to navigate as the standard release of these are diminished and correlate to the negative reward feedback system that encourages maladaptive coping and increased risk of relapse when under heightened stress (Cataldo et al., 2019; Kim et al., 2017). Traumatic experiences directly affect parenting practices including higher incidences of physical abuse, insecure parent-child attachment, and decreased maternal sensitivity or response to their child (Lange et al., 2018). Experiencing ACEs early in life are positively associated with a mother's current parenting stress, and this association follows a dose-response relationship (Lange et al., 2018).

Reversing an ACE score is not possible, but there are a variety of approaches to prevent and mitigate the immediate and long-term effects of ACEs. Disrupting the multigenerational occurrences of trauma aids in preventing heightened ACE scores in children of parents who have elevated ACE scores themselves. Providing support and teaching parents about their own ACEs is valuable, as this extends the knowledge and understanding to extinguish barriers to create healthier home lives and mitigate ACEs in their own children. Successful interventions implemented to reduce intergenerational transmission of ACEs include, but are not limited to, improving engagement between parent and child, setting boundaries, the use of family-centered treatment for substance misuse and use disorders, supporting community outreach programs, as well as state and local policy changes (CDC, 2022).

Between 2015-2019, 21.6 million children annually were reported to be living with at least one parent abusing a substance, with 58,000 reported in Kentucky (Ghertner, 2022). Single parents suffering from substance misuse, or substance use disorders or who are in recovery, were the target population of this quality improvement proposal. Single parents who are in active recovery from a substance use disorder are navigating sobriety, acclimating to the parenting role,

and enduring stressors such as custody conflictions, job placement challenges, and unstable housing. Although parental recovery is encouraged to prevent additional ACEs for their children, parents must develop appropriate and effective coping mechanisms and parenting skills to do so. Emphasizing parenting-skills programs that address atypical parenting behaviors and teach coping mechanisms may ameliorate the impact on the parent-child relationship, subsequently preventing adversities in their children and promote healthy child development.

Purpose

The purpose of this literature review was to examine the effect of substance use disorder on parenting, attachment and bonding in young children and parenting interventions that can reduce parenting stress while improving coping, resilience, bonding, and attachment for parents in substance use disorder recovery. The evidence was further applied to a specific parenting skills intervention not used by the project site analyzing potential merit in being added to programming.

Literature Review

A comprehensive literature search for current knowledge and applicability of articles related to parenting interventions integrated during or after substance use treatment were explored on CINAHL, PubMed, APA PsycINFO, Cochrane Library, and OVID Medline. The following Boolean strings were used: a) parenting interventions or parenting program or parenting training b) substance use disorder or substance abuse or substance use or drug abuse. Each Boolean string was combined by “AND” to search abstracts. All search engines were filtered with full-text, English language and published between 2017-2023. CINAHL produced 45 articles after abstract review, 7 articles were relevant to the topic. PubMed produced 249 articles, after duplicate articles were removed, and abstracts were reviewed, 5 articles were

chosen. APA PsycINFO produced 36 articles; after removal of duplicate articles and abstract review, 10 articles were extracted. MEDLINE and Cochrane Library were also utilized, in which no articles were found using the identified search criteria. A full-text analysis and quality grading was performed for the remaining 24 articles, resulting in 15 publications which were evaluated for this literature research.

Parents with substance use tend to express maladaptive emotional regulation leading to harsher parenting responses to their children (Cioffi et al., 2023; Dyba et al., 2019; Guyon-Harris et al., 2023; Milligan et al., 2020; Porreca et al., 2022; Romanowicz et al., 2019; Stover et al., 2017). A commonality addressed throughout the literature was the correlation between negative parenting skills related to increased parental stress and poor parent-child attachment that was directly associated with the parent's own disrupted attachment style as a child. Negative parenting skills include the inability to read a child's cues, heightened irritability, and reacting in an abusive manner; implying parents with substance use disorder who have a poor attachment style have a disadvantage that has created a pathway to substance use which continues a generational cycle (Guyon-Harris et al., 2023; Romanowicz et al., 2019; Stover et al., 2017). Poor attachment style, emotional dysregulation, hostility, and increased stress can also contribute to substance abuse, relapse and be associated with physically abusive behaviors contributing to intergenerational transmission of trauma (Stover et al., 2017).

The CDC emphasizes parenting interventions to reduce aforementioned effects of ACEs (CDC, 2023). This approach is echoed in the literature and suggests parenting interventions should be implemented concurrently in addiction treatment or recovery to benefit the parent and child (Barlow et al., 2019; Cioffi et al., 2023; Dyba et al., 2019; Lowell et al., 2023; Milligan et al., 2020; Moreland & McRae-Clark, 2018; Short et al., 2017; Sperlich et al., 2020; Stover et al.,

2017; Stover et al., 2019; Suchman et al., 2019). This is due to the insufficient dopamine receptors from prolonged substance use which directly affects the same neurological pathways that release dopamine for maternal reward when caring for their child (Guyon-Harris et al., 2023; Milligan et al., 2020; Porreca et al., 2022; Suchman et al., 2018). One systematic review concluded parenting interventions will exhibit greater outcomes when parents are willing to learn, and the intervention attends to the maternal emotional needs as well as mental health of the mother (Milligan et al., 2020).

Short et al. conducted a mindfulness intervention with mothers between 18-40 years of age with children less than 6 years of age to teach breath work and meditation to decrease stress with topics of stress versus stressor and how to handle stressful parenting moments, and parenting-skills to assist in building caring relationships between mother and child (2017). Although the specific parenting skills were not listed, the Parenting-Stress Index- Short Form (PSI-SF) was one of two tools that were applied to measure success of intervention in decreasing stress, in which findings were suggestive of this intervention aiding in reducing stress among mothers with high ACEs (Short et al., 2017). Similarly, Suchman et al., conducted an intervention termed “Mothering from the Inside Out”, which was another form of mentalization-based therapy with intent to improve parents’ recognition of their own emotions, so they are equipped to better understand their own child, assisting with child attachment, mother-child interaction, and more which found success compared to the usual treatment group (2017).

Parental stress was measured in four interventions, as either a primary or secondary outcome, and higher scores of parental stress were correlated with negative attachment and harsh parenting styles due to external stressors outweighing resources to healthily manage the stress. The Parenting Stress Index-Short Form is a self-administered analysis tool consisting of a 36-

items, which is condensed from the original 120-item tool, and grouped into three domains including parental distress, parent-child dysfunctional interaction, and difficult child. This tool was designed to be self-administered by parents with children from birth to 12 years of age and has a reliability coefficient of .96 or greater (APA, 2011). In all three studies, the PSI score decreased, indicating the interventions significantly reduced parental stress (Barlow et al., 2019; Dyba et al., 2019; Short et al., 2017).

The literature reviewed was limited to three pilot studies, including a randomized controlled trial and wait-listed randomized controlled trial. Only one intervention reviewed was replicated, demonstrating the lack of representation of parenting interventions implemented, studied, and found successful in parents with substance use. Of 16 articles, seven interventions were implemented and synthesized, with only one directly studying the relationship between parent curriculum and types of attachment styles pre and post interventions (Barlow et al., 2019).

In general, substance use treatment programs are ill equipped to provide parenting-skills programming to assist with rebuilding the parent-child bond and teaching new parenting methods (Suchman et al., 2018). The synthesized literature emphasizes the importance of concurrent parent-child interventions during substance use treatment and recovery, and inclusion of mental health curriculum to combat parental stress and emotional regulation. Most studies reviewed reported on mothers in recovery and the parent-child relationship compared to fathers or combined interventions that would be applicable to either parental figure.

Effective parenting interventions explore gaps in parent knowledge and assist to provide diverse ways to cope by practicing healthy parenting skills, managing stress, and promoting emotional regulation. Interventions found to be significantly clinically effective include mindfulness techniques which was correlated with positive parenting and decreased maternal

stress, improved emotional regulation, and improved parenting skills through healthier approaches (Cioffi et al., 2023; Barlow et al., 2019; Short et al., 2017; Stover et al., 2017). Methods that emphasize praising parents for their current abilities, have been shown to have greater outcomes than skill-based parenting interventions in which may come across to the parents that they are parenting incorrectly (Lowell et al., 2023). Focusing on what parents are doing correctly will heighten responsiveness from parents and decrease risk of increased stress, thus, less substance cravings and relapse (Great Kids Inc., 2023; Lowell et al., 2023; Milligan et al., 2020).

Hope at Home is a family-strengthening curriculum specifically designed to focus on the strengths of individuals' parenting skills, as opposed to skill-based teachings, for parents in all phases of recovery with children aged three years or younger (Great Kids Inc., 2023). Each module, unit, and handout were thoughtfully created by Great Kids Inc., incorporating evidence-based practices to build a curriculum that was applicable to parents in recovery.

The parenting skills curriculum includes six protective factors to support families including parental resilience, attachment and relationships, and concrete support for parents (Great Kids Inc., 2023). The Hope at Home manual contains five modules, segmented into units crafting 22 units in total. The first module, with two units, is mandatory to complete as it explains the purpose for Hope at Home to the parents and sets the foundation for the subsequent lessons. Hope at Home is designed to be completed in any order, and values quality of the lesson over quantity of lessons, allowing customization for participants' needs.

Project Purpose and Potential Impact

Parents who have previously suffered from substance misuse or have a substance use disorder have difficulty regulating emotions and typically express irritability, hostility, and

negative parenting reactions when interacting with their child which negatively impacts the development of a healthy parent-child relationship (Guyon-Harris et al., 2023). Hope at Home is an evidence-based family-strengthening curriculum designed for parents with SUD in all phases of recovery, to improve parent-child relationship, grow parental resilience, teach stress management, and optimize coping skills to mitigate the impact of adverse childhood experiences for their children. This quality improvement project intended to sustainably implement Hope at Home at ChooseWell Communities and demonstrate that implementation of the curriculum will decrease parenting stress among participants.

Rationale

ChooseWell Communities (CWC) is a local non-profit organization in Louisville, KY which accepts participants after successful substance abuse treatment with a mission to provide structure to parents sustaining sobriety while raising their children less than five years old. The importance of stability in the home for children up to age five is heavily emphasized due to the drastic, healthy brain development that occurs during these years. Congruently, longevity of sobriety is also determined in the first three years of recovery (ChooseWell Communities [CWC], 2023). Participation in CWC's program can be used in parents' testimonials in court to obtain custody of their children and more. It is dire to keep the structure of the family while providing sustainable support for those wanting to implement such drastic change to better themselves and be more present for their families. In the CWC 2021 annual report, all parents participating in the program had an ACE score of 6 or more (ChooseWell Communities [CWC], 2022, p. 6). In September 2022, a needs assessment was conducted with the executive director and program committee of ChooseWell Communities which concluded that the program needed a parenting curriculum which would reduce parenting stress, and improve parenting, bonding,

and attachment that would involve both the parents and their children. The intervention was directly influenced by the quantity of ACEs each of their participants experienced, with urgency to mitigate the effects of trauma in the participant's children.

Conceptual Framework

Srivastav et al. (2019) curated the Empower Action Model which illustrates core socio-ecological factors that contribute to resilience in children and adults who have experienced ACEs and is divided into four sublevels which are the socioecological model, protective factors, race equity and inclusion, and life course expectancy (p. 528). This model is represented as a circle format to elicit that resilience is influenced by several elements that are a continuum throughout early childhood and into adulthood. The inner circle signifies socioecological factors that impact resilience in both child and adult alike including public policy, community, organization, interpersonal or family, and individual or child (Srivastav et al., 2019, p. 527). The middle circle surrounding the inner socioecological model demonstrates the five protective factors considered in social determinants of health to mitigate ACEs (Srivastav et al., 2019, p. 528). Race equity and inclusion construct the outer circle which completes the model by combating institutional racism through inclusive environments while providing equal opportunities, enhancing further resilience (Srivastav et al., 2019, p. 529). Below the visual model is a line demonstrating the life course perspective which is summarized as the protective factors that occur throughout all stages of life (Srivastav et al., 2019, p. 529; see Appendix A).

Implementation of this project at ChooseWell communities will directly impact the socioecological model through its foundational protective factors including interpersonal, individual, organization and community. ChooseWell Communities evaluates yearly initiatives and sets an aim to incorporate sessions that directly address parenting skills in the 2024 fiscal

year. ChooseWell Communities mission is to assist young families, with children under five years of age, to maintain sobriety while also supporting the well-being of their family (CWC, 2023). Applying the Hope at Home curriculum, addressed four out of the five foundational factors of the Empower Action Model to disrupt further damage of trauma each week through direct discussion of parent-child bond, disrupting generational impairment caused by substance use.

Quality Improvement Model

This quality improvement project was developed with the ACE Star Model of Knowledge Transformation which is a 5-point star configuration each representing discovery research, evidence summary of synthesized literature, translation into action which combines expertise and evidence-based practices for best suitable action, integration into practice to assure alignment with most recent evidence, and evaluation to assess impact (Stevens, 2013). Each point on the star is interpretive of the stages of research one must complete to properly implement research into practice with minimal barriers, and provides a pathway to do so (Stevens, 2013). Discovery research, evidence summary, translation into guidelines, or otherwise known as points 1, 2 and 3, were examined throughout the initiation of the proposal portion of the quality improvement project. While practice integration and evaluation, or points 4 and 5, were fulfilled proceeding implementation of the quality improvement project (see Appendix B).

Methods

Project Design

This quality improvement project was implemented using a longitudinal pre-test and post-test approach, while concurrently utilizing a mixed methods design to determine the effect of Hope at Home on parenting stress of CWC parents. The independent variable in this project

was the Hope at Home curriculum. The dependent variables were parental stress, session attendance, and participant satisfaction. The sample was CWC parents who regularly attend Wednesday program support meetings.

By executing the mixed methods design, quantitative data was collected in the form of surveys, whereas qualitative data was collected via three open-ended questions answered by participants at the conclusion of the parenting sessions. The participants individually completed the surveys using paper and pencil.

The Hope and Home programming consisted of an eight-week curriculum, allowing parents to attend each lesson weekly. The program committee at CWC was informed during bi-monthly meetings of the intervention progression, in which the committee then informed participants of the upcoming family-strengthening curriculum dates. The eight lessons implemented were explicitly selected from the Hope at Home manual to correlate to the 2024 aims of the ChooseWell Communities strategic plan, with intention to best serve their parent participants.

The eight lessons were conducted in 45 to 60-minute sessions and covered the following topics: Attachment, healthy ways of coping, recognizing stress overload, and showing appreciation and love to their child (Great Kids Inc., 2023; see Appendix H). Corresponding handouts and activities were assigned to support the weekly curriculum and were designated by the manual to reinforce secure attachment.

Each lesson incorporated a foundational model, The 4 Me's, created by Great Kids Inc. which served as a weekly reminder to parents of how their day-to-day interactions supports secure attachment with their child, even at the prenatal stage (Great Kids Inc., 2023). The 4 Me's model, as demonstrated in Appendix G, consists of 4 principal categories involving Encourage

Me, See Me, Connect with Me, and Nurture Me; each with sub examples of how parents may demonstrate and incorporate this into their relationship with their child. Each weekly module incorporated one aspect of the 4 Me's into the curriculum, further enhancing parents' understanding and reassuring them of their parenting practices while reinforcing positive parent-child interactions. An example under the "Encourage me" category is to point out the child's effort and to let the child know how proud the parent is of them. Each was thoroughly explained to the parents during the initial module. At week two, parents created a personalized version of the The 4 Me's model, serving as a reminder of how they can integrate this model while encouraged to intentionally reference it daily and at each weekly session throughout the program (Great Kids Inc., 2023).

CWC supported the implementation of the Hope at Home curriculum by allowing for the delivery of the project during scheduled weekly meetings in a CWC meeting room on Wednesday evenings. CWC provided childcare for parent participants and purchased the Hope at Home program and manual. Participants were gathered from a convenience sample as all members have children less than five years of age and reside in CWC-sponsored housing. There was not exclusion criterion as all parents were politely asked to participate in collection of data to assess parenting stress before and after parenting sessions, with anticipation of an average weekly sample of 25 parents. Although weekly meetings are required, life events prevented some parents from attending consistently.

Hope at Home was introduced the first week to parent participants to learn about the purpose and how each weekly session would be delivered. Parents were highly encouraged to come each week to improve their experience and maximize the impact of programming. With consent, parents anonymously reported demographic data and completed a pre-test prior to

initiation of Hope at Home. Identity of parents was preserved by participants constructing a unique identifier in which they would label each pre-and post-test, survey, and weekly attendance sheet. Permission was given to attend weekly sessions to parents who opted out of the data collection process because the Hope at Home curriculum was in place of regularly planned programming at CWC. Upon conclusion of the program, parents who consented to data collection completed a post-test and satisfaction survey.

This project required approximately 12 hours of implementation time, including two hours of online training, and eight weeks of one-hour sessions. Additional time was utilized for collecting materials, assembling copies of weekly handouts, and examining weekly modules prior to implementation.

Stakeholders

Key stakeholders in this quality improvement intervention involved the parents of CWC, CWC Board of Directors, and the CWC Program Committee. This project was designed intentionally to meet the 2024 CWC initiative of integrating parenting-skills interventions within their programming.

Budget

The overall cost for this quality improvement project was $1,027.15, including the Hope at Home manual which was purchased by CWC. Other items incorporated into weekly parenting sessions included the PSI-SF, printer paper, multicolored card stock, magnets for activities, self-adhesive laminating sheets, folders with prongs for parents to create their own Hope at Home parent handbook, and age-appropriate books for children.

Measures

Demographics

Demographic data including participants' age, gender, race, number of children, age of children, and race of children was collected during the initial session of Hope at Home (Appendix E).

Parenting Stress Index-Short Form (PSI-SF)

After conducting a literature review of measures of parenting stress, the Parental Stress Index-Short Form (PSI-SF) was chosen to measure parents' stress before and after implementing Hope at Home curriculum at weeks one and eight. At four-week post- intervention, also referred to as week 12, the PSI-SF was administered to evaluate the impact of the curriculum on parental stress and the sustainability of these findings longer term. The PSI-SF was used to determine if parents report less stress or improved coping mechanisms for stress after strengthening their parenting skills. Theoretically, decreasing stress and improving coping for stress should create better parent-child bonding, less reactive parenting responses, and less urgency for substance use relapse (Barlow et al., 2019; Dyba et al., 2019; Short et al., 2017; Wu, 2017).

The original parenting stress index (PSI) was created by Richard Abidin in 1983 and consists of 120-items for parents with children 12 years of age or younger, measuring three domains including parental distress (PD), parent-child dysfunctional interaction (PCDI), and difficult child (DC) (Wu, 2017). The short form is a condensed version consisting of a 36-item analysis and measures these domains on a smaller scale and can be completed within 10 minutes. The form utilizes a Likert-scale with responses ranging from strongly disagree to strongly agree (see Appendix C).

Richard Abidin originally reported Cronbach's alpha of .91, with the subsections concluding .87 for PD, .80 for PCDI, and .85 for DC and test-retest reliability overall of .84 (Lee at al., 2016; Wu, 2017). The validity and reliability of this instrument was verified in a study of

minorities consisting of 240 African American and Latino caregivers in a 16-week program which aimed to strengthen parenting skills and family relationships (Lee et al., 2016, p. 4). They found similar validity with .92 Cronbach's alpha for the overall the PSI-SF scale, .89 for the PD subscale, .82 for the PCDI subscale, and .83 for the DC subscale indicating internal consistency (Lee et al., 2016).

Attendance

Attendance was recorded at each session by parents providing their unique identifiers on a sign-in sheet to measure engagement with the curriculum. Parents were encouraged to attend each week to enhance the benefits from the family-strengthening curriculum and promote consistency and usability of the intervention strategies.

Satisfaction with Hope at Home

Participant satisfaction was assessed to understand the impact of satisfaction on the efficacy of the parenting intervention. Thus, participant satisfaction data was collected via a Likert scale questionnaire with an open-ended question at the end of programming and used to determine the program's relevancy, efficacy, and sustainability. The Likert Scale was designed for parents to express the impact or benefits received from the Hope at Home curriculum (see Appendix F).

Ethical Considerations

Ethical Permission

This proposal was submitted and granted permission via the University of Louisville IRB prior to implementation of Hope at Home at ChooseWell Communities. Furthermore, ChooseWell Communities granted approval for project implementation and purchase of the

Hope at Home curriculum. Data was collected using unique identifiers for each participant which was locked in a storage box, behind a locked office door to ensure confidentiality.

Data Stewardship

Data collected was stored on an encrypted and password-protected laptop. Unique identifiers were on all pertinent forms completed by participants including demographics, pre- and post-test PSI scores, and satisfaction surveys. The unique identifier was created by the participants using the first three letters of their elementary school combined with the last three digits of their phone number. This ensured participant confidentiality and anonymity were maintained throughout the project. A list of participant identifiers maintained on project laptop, with a hard copy kept behind two lock entities.

Data Analysis

Data was analyzed by the Statistical Package for Social Sciences (SPSS) version 29. Demographic data collected consisted of participant age, gender, race, number of children, age, and race of children before implementation and analyzed via descriptive statistics. Dependent t-tests were calculated to measure and compare the average of pre- and post PSI-SF scores of all participants. Scores collected at week one were compared to scores collected at week eight and week 12, to evaluate the impact of the Hope at Home parenting intervention on participants' parental stress. Independent t-tests were used to compare the average pre- and post- PSI-SF scores between male and female participants from program start to week eight, and week 12 assessments to determine the impact of Hope at Home on parenting stress and assess any differences between mothers and fathers. A Pearson correlation coefficient was calculated to measure the relationship between the number of Hope at Home sessions completed to PSI-SF score post implementation at week eight, which completes the curriculum, and week 12 (four-

weeks post-intervention). Hope at Home satisfaction Likert scale scores were analyzed using descriptive statistics, while the open-ended question of participant satisfaction was evaluated using thematic analysis.

The project's results will be shared with ChooseWell Communities executive director and program committee board, Great Kids Inc. who own the rights of Hope at Home, and at the Sigma Theta Tau conference. The program outcomes will be disseminated via university poster presentation and the final manuscript submitted for publication.

Results

Demographics

Upon initiation of the quality improvement project, 22 participants consented to data collection including demographics, attendance, pre- and post- PSI-SF scores, and a satisfaction survey of the Hope at Home curriculum. Of these 22 participants, 16 were female and six were male. There was a wide range of ages from 20 to 45 years, with 40.9% of participants between 31-35 years old. Of the parent participants, 13.6% identified as African American, 81.8% Caucasian, and 4.5% multi or biracial (Table 1).

The mean number of children of each participant was 2.27 (SD=1.486), with a mean age less than 5 years equating to 1.36 (SD=0.581). Race of children reported differed from the parent participants as 9.1% identified as African American, 68.2% identified as Caucasian, and 22.7% reported muti or biracial in comparison.

Table 1

ChooseWell Communities Participant Demographic Data (n=22)

Characteristic	n	%
Gender		
Female	16	72.7
Male	6	27.3

Age Range		
20-25	2	9.1
26-30	4	18.2
31-35	9	40.9
36-40	5	22.7
41-45	1	4.5
46-50	1	4.5
Race of Participants		
African American	3	13.6
Caucasian	18	81.8
Multi or Biracial	1	4.5
Total # of Children Participant has		
1	10	45.5
2	3	13.6
3	5	22.7
4	2	9.1
5	1	4.5
6	1	4.5
Number of Children Less Than 5 Years old		
1	15	68.2
2	6	27.3
3	1	4.5
Race of Children		
African American	2	9.1
Caucasian	15	68.2
Multi or Biracial	5	22.7

Attendance

Although not required, attendance was highly encouraged for participants as they would acquire the most benefit from the complete eight-week course. Initially, 22 participants consented to data collection, in which 13.6% had perfect attendance throughout the curriculum with a mean of 5.55 classes attended (SD=2.132), median of 6 and mode of seven classes attended. While attendance of seven classes had the highest percentage at 31.8% of participants.

To assess if there was a relationship between the number of Hope at Home sessions attended with PSI scores at eight weeks, a Pearson r correlation coefficient was computed as r = -

.572 (p=.066) indicating a moderately negative correlation. The post-12-week PSI-SF total stress scores were calculated with a r value of -0.493 (p=.70), similarly indicating a moderately negative correlation. This suggests that attending more Hope at Home parenting sessions was associated with decreased parenting stress, however neither Pearson coefficients are statistically significant (Tables 2 and 3).

Table 2

Relationship between Attendance and post-8-week PSI-SF Stress Scores

	Mean	SD	N	Number of classes attended of 8	Post 8-week PSI-SF Total Stress
Number of classes attended of 8	5.55	2.132	22		
Pearson correlation				1	-.572
Sig. (2-tailed)					.066
Post 8-week PSI-SF Total Stress	67.18	23.638	11		
Pearson Correlation				-.572	1
Sig. (2-tailed)				.066	

Note. N= number of total participant responses

Table 3

Relationship between Attendance and post-12-week PSI-SF Stress Scores

Variable	Mean	SD	N	Number of classes attended of 8	Post 12-week PSI-SF Total Stress
Number of classes attended of 12	5.55	2.132	22		
Pearson Correlation				1	-.493
Sig. (2-tailed)					.74
Post 12-week PSI-SF Total Stress	65.64	20.746	14		
Pearson Correlation				-.493	1
Sig. (2-tailed)				.074	

Note. N= number of total participant responses

Parental Stress

To examine the effect of the Hope at Home curriculum on parental stress, pre-intervention PSI-SF scores were compared to post-intervention PSI-SF scores at eight and 12

weeks via t-tests. Paired t-tests were used to compare participants' pre-PSI-SF results to post-8-week intervention PSI-SF (p=.065), then again to compare the pre-PSI-SF results to the post-12-week intervention PSI-SF (p=.030). Finally, means were compared to determine the sustainability of decreased stress from post-8-weeks PSI-SF scores to post-12-weeks PSI-SF scores (p=.906). Pre-intervention PSI-SF scores were not significantly different from the scores obtained at eight weeks nor between the scores obtained at 8 weeks when compared to scores obtained at 12 weeks, however, the results for pre-PSI-SF total stress to post-12-week total stress scores had a p value of .030 indicating a statistically significant decrease in parenting stress from program initiation compared to 12 weeks from program start (Table 5).

Independent t-tests were analyzed to assess differences in male versus female participants and total stress scores. Descriptive statistics for both genders and PSI-SF scoring are represented in Table 6. At the pre-PSI-SF assessment, there were 16 females with a mean score of 80.00 (SD=28.533) and 6 males with a mean score of 75.83 (SD=20.004). The following assessment at post-8-week PSI-SF collection there were 9 females with a mean score 69.67 (SD=23.875) and 2 males with a mean score of 56.00 (SD=25.870). At the post-12-week PSI-SF data collection there were 10 females with a mean score of 72.20 (SD=19.136) and 4 males with a mean score of 49.25 (SD=16.276). Independent t-tests are represented in Table 7, with pre-PSI-SF p value of .747, post-8-week PSI-SF p value of .489, and post-12-week PSI-SF p value of .57. All values indicating the failure to reject the null hypothesis.

Participant Satisfaction

The satisfaction survey was provided to the participants proceeding week eight content (Appendix F). Participants were encouraged to express how this program may or may not have helped them, while reminded that responses were anonymous.

Table 4

PSI-SF Total Stress Descriptive Statistics

Variables	Mean	N	Std. Error Mean	SD
Pre-PSI-SF Total Stress	75.00	11	7.896	26.188
8-week Post PSI-SF Total Stress	67.18	11	7.127	23.638
Pre-PSI-SF Total Stress	79.64	14	7.216	27.000
12-week Post PSI-SF Total Stress	65.64	14	5.545	20.746
Post 8-week PSI-SF Total Stress	67.18	11	7.127	23.638
Post 12-week PSI-SF Total Stress	66.64	11	5.721	18.975

Table 5

Paired Sample T-Test PSI-SF Total Stress Scores

		Paired Differences							Significance
					95% CI				
		Mean	SD	Std. Error Mean	Lower	Upper	t	df	Two-sided p
Pair 1	Pre-PSI-SF Total Stress to Post-8-week PSI-SF Total Stress	7.818	12.536	3.780	-.604	16.240	2.068	10	.065
Pair 2	Pre-PSI-SF Total Stress to Post-12-week PSI-SF Total Stress	14.000	21.573	5.766	1.544	26.456	2.428	13	.030
Pair 3	Post-8-week PSI-SF Total Stress to Post-12-week PSI-SF Total Stress	.545	14.962	4.511	-9.506	10.597	.121	10	.906

Table 6

Descriptive Statistics of Gender and PSI-SF Total Stress

	N	Mean	SD	Std. Error Mean
Pre-PSI-SF Total Stress				
Female	16	80.00	28.533	7.133
Male	6	75.83	20.004	8.167
Post-8-week PSI-SF Total Stress				
Female	9	69.67	23.875	7.958
Male	2	56.00	25.870	19.000
Post-12-week PSI-SF Total Stress				
Female	10	72.20	19.136	6.051
Male	4	49.25	16.276	8.138

Table 7

Independent T-Test PSI-SF Total Stress Male to Female

			Significance			95% CI	
	t	df	Two-sided p	Mean Difference	Std. Error Difference	Lower	Upper
Pre-PSI-SF Total Stress	.327	20	.747	4.167	12.761	-22.453	30.787
Post-8-week PSI-SF Total Stress	.722	9	.489	13.667	18.938	-29.174	56.508
Post-12-week PSI-SF Total Stress	2.101	12	0.57	22.950	10.923	-.848	46.748

Of the consented participants, 13 contributed feedback on the satisfaction survey representing 59% response rate, which can be examined in Table 8.

Table 8

Participant Satisfaction Survey (n=13)

Survey Statement	Mean Score
The lessons I learned through Hope at Home helped me focus on my strengths as a parent	4.23
I feel better equipped to focus on my strengths to help the bond between my child and me	4.23
I would recommend Hope at Home to every parent in recovery at ChooseWell Communities	4.62

Note. Scale: Strongly Disagree (1), Disagree (2), Neutral (3), Agree (4), Strongly Agree (5)

Participant Perspectives

The satisfaction survey was proceeded by three open-ended questions, see Appendix F, that examined what benefitted the participant the most throughout the program, barriers they encountered that hindered them from practicing new parenting techniques, and if their child was responsive to the techniques they applied. A thematic analysis was performed to identify commonalities amongst parents in which they reported they had better coping skills for handling stress or stressful situations, felt more connected with their child and appreciated how the program reinforced their parenting strengths and techniques they were already doing. Parents also reported time as a barrier to practicing new parenting skills with their children whether it was during the day, afterwork, or limited time regarding custody. Other parents reported not experiencing barriers to performing new parenting skills including taking the time to listen, slow down, see the child and encourage them. A common theme amongst parents when asked if their child was responsive to the new skills was the enhanced relationship they had with their child and having improved communication relating to purposeful quality time to help bond with them including reading, cooking, or watching a movie together.

Miscellaneous

Missing data was coded into SPSS as a value of 999 to assure calculations of the data were not influenced or skewed by missing values. Full data collection was analyzed on 11 of the 22 initial participants, consequently indicating coded missing values were indicated.

Discussion

The quality improvement project envisioned to sustainably implement Hope at Home curriculum to parents in recovery with children less than 5 years of age to increase bonding and strengthen parenting skills while decreasing parental stress as measured by the PSI-SF forms. There were considerable variables and calculations analyzed to emphasize the success of the implementation at ChooseWell Communities.

Key findings

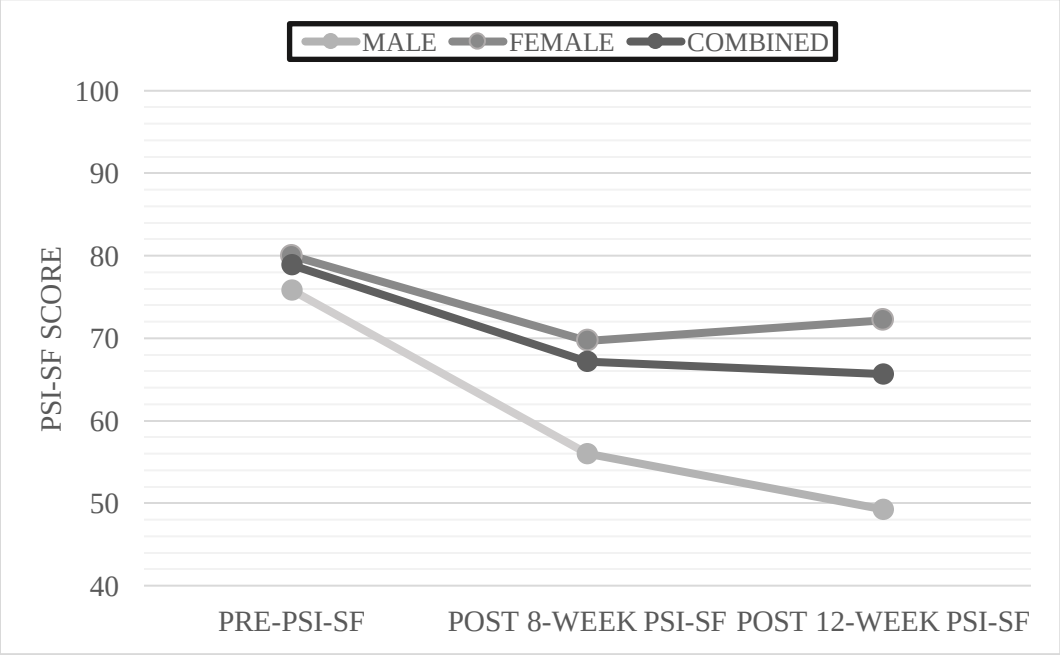
Although the majority of data analyses were not statistically significant, the pre-PSI-SF to post-12-week PSI-SF total scores when computed in a paired t-test had a statistically significant *p* value of .030 suggesting rejection of the null hypothesis indicating there was a statistical significance in decrease of total stress scores from pre-data collection of PSI-SF to the post-12-week PSI-SF data collection. This may imply participants were able to sustainably practice Hope at Home parenting-skills in which improved their bond with their child; thus, decreasing overall stress. Warning signs of stress and learning healthy ways of coping were important topics covered in the Hope at Home curriculum.

Over the course of the quality improvement project, the PSI-SF average scores decreased at each data collection point when compared to the initial collection of PSI-SF forms as illustrated in Figure 1. The general goal of the quality improvement project was aimed to decrease parenting stress. Through analysis of the data this goal was achieved in both genders at the post-8-week and post-12-week data collection. Participant satisfaction surveys had high

acceptance and agreeance to feedback regarding programming. Parents were grateful to have a curriculum that encouraged them to focus on their strengths as opposed to critiquing their parenting skills. An important theme discovered when evaluating patient perspectives is that parents reported improved communication relating to purposeful quality time to help bond with their child; therefore, promoting a secure attachment with their child. The curriculum is designed to strengthen this aspect of relationships between parent and child which is notable by the results the participant's experience.

Figure 1

Changes in PSI-SF Total Stress over 12-weeks



Attendance

Although results were not statistically significant, both Pearson r correlation coefficient results demonstrated a moderately negative correlation which is suggestive that total stress decreased as more sessions were attended at the post-8-week and post-12-week data collection. The post-12-week PSI-SF total stress scores were collected 4-weeks post curriculum, and results

of the Pearson correlation coefficient resulted in a moderately negative correlation which is additionally suggestive that the total stress of participants remained decreased 4-weeks out from the final Hope at Home session, as the number of sessions completed increased.

ChooseWell Communities promoted attendance by collaborating with Great Kids Inc. who created certificates of completion for the parenting-skills curriculum, Hope at Home. Certificates of completion were given to participants who attended at least 6 of 8 Hope at Home classes. This incentivized parents as they could use this certificate to show their social worker the parenting-skills curriculum they had been working on over the span of 2 months. Parents who did not meet the requirement of at least 75% of classes attended were still given a certificate of participation to imply gratitude for partaking in Hope at Home.

Defensive Responding

One aspect measured within the PSI-SF is parental distress (PD) in which included a subscale, named defensive response (DR), that is measured by the score of 7 of the 12 total questions that make up the PD section of the scoring sheet. The subscale is incorporated to assess bias of whether the parent is attempting to portray themselves in a more favorable manner to mitigate the impression of stress or problems in the parent-child relationship (Abidin, 2012, p. 59). When calculating total scores for PD, it is favored to score those 7 questions separately to form a defensive response (DR) score with a score less than 10 indicating the parent is either responding defensively. The minimum score for the DR subscale is 7 while the maximum score is 35. These scores are calculated via a likert scale that is posed for each question on the PSI-SF screening tool.

There are several hypotheses listed that may be suggestive of a defensive response score of less than 10 which include: the parent is attempting to portray themselves as a competent

parent in which does not experience these stresses, the parent is not as invested in the child's life as portrayed thus they are not experiencing the typical stresses associated with parenting a child, or the parent is competent, handles the typical stresses well while also having health relationships outside the parent-child bond (Abidin, 2012, p. 59). The purpose of this quality improvement project was to assess the stress amongst parents in recovery, initiate a parenting-skills curriculum intervention and reassess whether it decreased the stress amongst parents thus improving bond. Due to the nature of the quality improvement project and proposed goal of achieving a statistically significant decrease in PSI-SF scores, as well as a small sample size of participants, the corresponding hypothesis for each participant with a score less than 10 cannot be properly assumed.

Limitations

There is limited generalizability to practice and implementation in other recovery programs as each program is unique. Due to weekly attendance not being mandatory, it effected consistency in attendance; thus, effecting accuracy of data collection and creating a smaller sample size to be analyzed. Attendance was a weakness in the design of the project. With improved adherence and consistency of participant engagement, more data would have been available to analyze of the participants. Each week, efforts were implemented to assure all participants had signed the attendance sheet with their unique identifier through several verbal reminders and physically handing the attendance sheet to each table to complete. Attendance also contributed to decreased follow-up of participants that did not fill out data collection or follow-up forms at post-intervention in full.

Future Recommendations

ChooseWell Communities was receptive to dissemination of results and believed Hope at Home was a success to their programming. CWC will begin utilizing Hope at Home parenting skills curriculum in their orientation of the programming when parents are entering. It was suggested that CWC allow the parents to partake in choosing parenting topics they are interested in to assist in receptibility from the parents. CWC states they have recently begun involving the parents in regular programming to which they agreed they are more responsive to the weekly lessons. A board member of CWC programming committee, whom is also a board certified PMHNP, will be assisting in providing the teachings of Hope at Home during orientation. The added programming into orientation may consist of 4 to 6 classes, held once weekly, but the exact number of sessions is still being discussed. During these sessions it was suggested that parents have recap sheets to document valuable lessons that they learned from that week, in addition to the work sheets that correspond with each session, to provide an outlook for them to express how they may incorporate it into their daily lives.

Attendance was a contributable factor within the quality improvement project, in which CWC was applauded for setting the standard and having completion certificates arranged for those who met the attendance criteria to receive one. It was emphasized that incentivizing attendance is a great way to increase compliance which may include completion certificates, gift cards, and more, to which they agreed. It was disclaimed the parenting stress scores did not consider parents who did not have custody or had open social worker cases, in which they may have been more motivated to receive certificates of completion to show in court. These scores may have decreased as well if custody was granted back to the parent during the time Hope at Home was implemented.

For future implications, it is suggested that participants who consent to data collection must understand the importance of adhering to the curated programming to best benefit for themselves and the project coordinator. Incentives for attendance would likely increase adherence, or a program in which that could be recorded for those that miss that week so they may still benefit from the weekly curriculum. A larger sample size would likely provide adequate data collection to better analyze the effects of parenting skills curriculum to parental stress.

Conclusion

Effects of adverse childhood experiences may be mitigated through several pathways with one being implementing parenting-skills curriculum concurrently in recovery programming to decrease parental stress, promote parent-child secure attachment and reduce relapse in parents (CDC, 2022; Cioffi et al., 2023; Lowell et al., 2023; Milligan et al., 2020; Stover et al., 2017; Suchman et al., 2018). Additional studies directly measuring the effects of parenting interventions with parents suffering from substance use disorder for improving bonding and attachment with their children is needed. Literature recommendations regarding this specific population is narrow which hinders future quality improvement projects or studies from being implemented to aid in reducing the effects of ACEs and improving bonding between the child and parent in recovery. The quality improvement project utilized an 8-week course discussing parenting-strengthening skills each week to promote enhanced parent-child relationships while concurrently decreasing parental stress. Hope at Home Curriculum exceeded expectations and promoted a healing environment for parents to discover, encourage, and reassure themselves that they have the skills to be the model parent they want to be for their child in recovery and after.

References

Abidin, Richard R. (2012). Parenting stress index. *PAR, 4*, 57-64.

America's Health Rankings. (2021). Explore adverse childhood experiences in kentucky. https://www.americashealthrankings.org/explore/annual/measure/ACEs_8/state/KY

American Psychological Association. (2011). Parenting stress index. *American Psychological Association.* https://www.apa.org/pi/about/publications/caregivers/practice-settings/assessment/tools/parenting-stress

American Psychological Association. (2022). Substance use, abuse, and addiction. *American Psychological Association*. https://www.apa.org/topics/substance-use-abuse-addiction

American Society for the Positive Care of Children. (n.d.). *Get the facts: Adverse childhood experiences (aces).* American SPCC. Retrieved October 10, 2022, from https://americanspcc.org/get-the-facts-adverse-childhood-experiences/#.

Barlow, J., Sembi, S., Parsons, H., Kim, S., Petrou, S., Harnett, P., & Dawe, S. (2019). A randomized controlled trial and economic evaluation of the parents under pressure program for parents insubstance abuse treatment. *Drug and alcohol dependence, 194*, 184–194. https://doi.org/10.1016/j.drugalcdep.2018.08.044

Cataldo, I., Azhari, A., Coppola, A., Bornstein, M. H., & Esposito, G. (2019). The influences of drug abuse on mother-infant interaction through the lens of the biopsychosocial model of health and illness: a review. *Frontiers in public health, 7*, 45. https://doi.org/10.3389/fpubh.2019.00045

Centers for Disease Control and Prevention. (2019). *CDC Vital signs. Adverse childhood experiences (ACEs) preventing early trauma to improve adult health, 2.* https://www.cdc.gov/vitalsigns/aces/pdf/vs-1105-aces-H.pdf

Centers for Disease Control and Prevention. (2022, March 17). *About the cdc-kaiser ace study*. CDC. https://www.cdc.gov/violenceprevention/aces/about.html

Centers for Disease Control and Prevention. (2023, June 29). *Fast facts: Preventing adverse childhood experiences. Centers for Disease Control and Prevention.* https://www.cdc.gov/violenceprevention/aces/fastfact.html#:~:text=Preventing%20ACEs,-Strategy&text=Raising%20awareness%20of%20ACEs%20can,%2C%20depression%2C%20or%20suicidal%20thoughts

ChooseWell Communities. (2022). CWC annual report - 2021 [PDF]. https://static1.squarespace.com/static/5e5d751236780c41fb5478d1/t/62b84628773ee216eccf7a12/1656243760657/cwc+annual+report+-+2021.pdf

ChooseWell Communities. (2023). *What we do*. https://www.choose-well.org/what-we-do

Cioffi, C. C., Browning O'Hagan, A. M., Halvorson, S., & DeGarmo, D. S. (2023). A randomized controlled trial to improve fathering among fathers with substance use disorders: fathering in recovery intervention. *Journal of Family Psychology.* Advanced online publication. https://dx.doi.org/10.1037/fam0001134

Dyba, J., Moesgen, D., Klein, M., Pels, F., & Leyendecker, B. (2019). Evaluation of a family-oriented parenting intervention for methamphetamine-involved mothers and fathers-the shift parent training. *Addictive behaviors reports*, *9*, 100173. https://doi.org/10.1016/j.abrep.2019.100173

Gannon, M. A., Mackenzie, M., Hand, D. J., Short, V., & Abatemarco, D. (2019). Application of a re-aim evaluation framework to test integration of a mindfulness based parenting intervention into a drug treatment program. *Maternal and Child Health Journal, 23*(3), 298-306. https://doi.org.echo.louisville.edu/10.1007/s10995-018-02715-y

Ghertner, R. (2022). U.S. national and state estimates of children living with parents using substances, 2015-2019. *Assistant Secretary for Planning and Evaluation.* https://aspe.hhs.gov/sites/default/files/documents/c5993cdc2c8d78771442a34124acda84/Parental-Behavioral-Health-and-Child-Maltreatment.pdf

Great Kids Inc. (2023). Hope at home. *Great Kids Inc.*

Guyon-Harris, K., Jacobs, J., Lavin, K., & Moran Vozar, T. E. (2023). Perinatal substance use and the underpinnings of addiction and attachment: Implications for parenting interventions. *Practice Innovations, 8*(2), 75-88. https://doi.org/10.1037/pri0000199

Kentucky Youth Advocates. (2021). *Kentucky kids and adverse childhood experiences: Quick facts about aces* [PDF]. https://kya.wpenginepowered.com/wpcontent/uploads/2021/12/2022-Bloom-Policy-Priorities-Packet.pdf

Kentucky Youth Advocates. (2022a). *Adverse childhood experiences: How common are they in the jefferson region?* [PDF]. https://kya.wpenginepowered.com/wpcontent/uploads/2022/09/BloomKY_ACEs_Jefferson.pdf

Kentucky Youth Advocates. (2022b, January 18). *Bloom kentucky announces 2022 state policy and budget priorities*. https://kyyouth.org/bloom-kentucky-announces-2022-state-policyand-budget-priorities/

Kim, S., Iyengar, U., Mayes, L. C., Potenza, M. N., Rutherford, H. J. V., & Strathearn, L. (2017). Mothers with substance addictions show reduced reward responses when viewing their own infant's face. *Human brain mapping*, *38*(11), 5421–5439. https://doi.org/10.1002/hbm.23731

Lee, S. J., Gopalan, G., & Harrington, D. (2016). Validation of the parenting stress index-short form with minority caregivers. *Research on social work practice, 26*(4), 429–440. https://doi.org/10.1177/1049731514554854

Lowell, A. F., DeCoste, C., Dalton, R., Dias, H., Borelli, J. L., Martino, S., McMahon, T. J., & Suchman, N. E. (2023). Mothering from the inside out: results of a community-based randomized efficacy trial testing a mentalization-based parenting intervention for mothers with addictions. *Infant Mental Health Journal, 44*(2), 142-165. https://doi-org.echo.louisville.edu/10.1002/imgj.22043\

Milligan, K., Meixner, T., Tremblay, M., Tarasoff, L. A., Usher, A., Smith, A., Niccols, A., & Urbanoski, K. A. (2020). Parenting interventions for mothers with problematic substance use: A systematic review of research and community practice. *Child Maltreatment, 25*(3), 247-262. https://doi-org.echo.louisville.edu/10.1177/1077559519873047

Moreland, A. D., & McRae-Clark, A. (2018). Parenting outcomes of parenting interventions in integrated substance-use treatment programs: A systematic review. *Journal of substance abuse treatment, 89*, 52–59. https://doi.org/10.1016/j.jsat.2018.03.005

Porreca, A., Simonelli, A., De Carli, P., Barone, L., Filippi, B., Rigo, P., Van IJzendoorn, M. H., & Bakermans-Kranenburg, M. J. (2022). A randomized wait-list controlled trial to investigate the role of cognitive mechanisms in parenting interventions on mothers with substance use disorder. Trials, *23*(1), 1-15. https://doiorg.echo.lousville.edu/10.1186/s13063-022-06420-8

Romanowicz, M., Vande Voort, J. L., Shekunov, J., Oesterle, T. S., Thusius, N. J., Rumans, T. A., Croarkin, P. E., Karpyal, V. M., Lynch, B. A., & Schak, K. M. (2019). The effects of

parental opioid use on the parent-child relationship and children's developmental and behavioral outcomes: A systematic review of published reports. *Child & Adolescent Psychiatry & Mental Health, 13*(1). https://doi-org.echo.louisville.edu/10.1186/s13034-019-0266-3

Saxon, A. (2023). Addiction and substance use disorders. *American Psychiatric Association*. https://www.psychiatry.org/patients-families/addiction-substance-use-disorders

Short, V., Gannon, M., Weingarten, W., Kaltenbach, K., LaNoue, M., & Abatemarco, D. (2017). Reducing stress among mothers in drug treatment: A description of a mindfulness-based parenting intervention. *Maternal & Child Health Journal, 21*(6), 1377-1386. https://doi-org.echo.louisville.edu/10.1007/s10995-016-2244-1

Sperlich, M. I., Bascug, E. W., Green, S. A., Koury, S., Hales, T., & Nochajski, T. H. (2021). Trauma-informed parenting education support groups for mothers in substance abuse recovery. *Research on Social Work Practice, 31*(7), 742-757. https://doi-org.echo.louisville.edu/10.1177/10497315211007568

Srivastav, A., Strompolis, M., Moseley, A., & Daniels, K. (2020). The empower action model: A framework for preventing adverse childhood experiences by promoting health, equity, and well-being across the lifespan. *Health Promotion Practice, 21*(4), 525-534. doi:10.1177/1524839919889355

Stevens, K. R. (2013). The impact of evidence-based practice in nursing and the next big ideas. *The Online Journal of Issues in* Nursing *18*(2). https://doi.org/10.3912/OJIN.Vol18No02Man04

Stop Abuse Campaign. (n.d.). *What does your ace score mean?* https://stopabusecampaign.org/take- your-ace-test/what-does-your-ace-score-mean/

Stover, C. S., Carlson, M., & Patel, S. (2017). Integrating intimate partner violence and parenting intervention into residential substance use disorder treatment for fathers. *Journal of Substance Abuse Treatment, 81,* 31-45. https://doi-org.echo.louisville.edu/10.1016/j.jsat.2107.07.013

Stover, C. S., McMahon, T. J., & Moore, K. (2019). A randomized pilot trial of two parenting interventions for fathers in residential substance use disorder treatment. *Journal of substance abuse treatment*, *104*, 116–127. https://doi.org/10.1016/j.jsat.2019.07.003

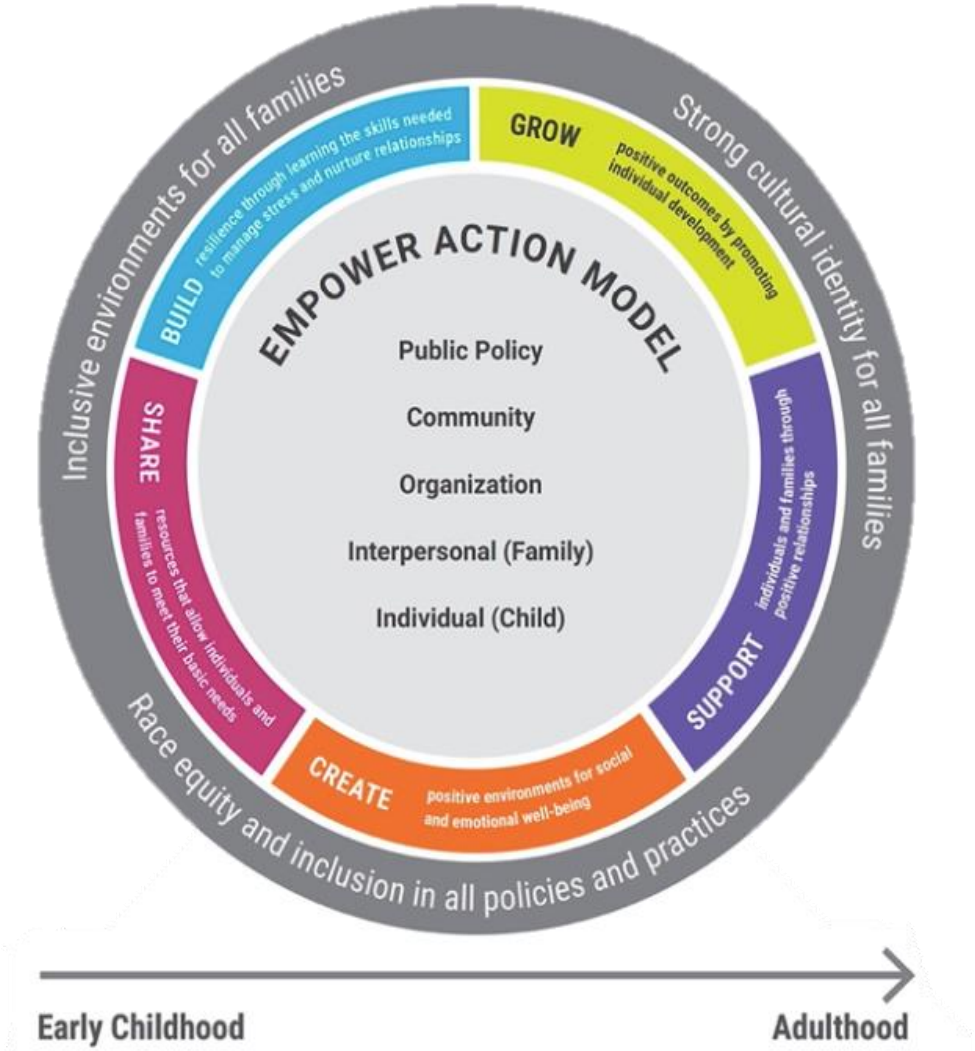
Suchman, N. E., DeCoste, C. L., McMahon, T. J., Dalton, R., Mayes, L. C., & Borelli, J. (2017). Mothering from the inside out: Results of a second randomized clinical trial testing a mentalization-based intervention for mothers in addiction treatment. *Development and psychopathology*, *29*(2), 617–636. https://doi.org/10.1017/S0954579417000220

Suchman, N. E., DeCoste, C., Borelli, J. L., & McMahon, T. J. (2018). Does improvement in maternal attachment representations predict greater maternal sensitivity, child attachment security and lower rates of relapse to substance use? A second test of mothering from the inside out treatment mechanisms. *Journal of substance abuse treatment*, *85*, 21–30. https://doi.org/10.1016/j.jsat.2017.11.006

Wu, James. (2017). Parenting stress index, short form. *The National Child Traumatic Stress Network.* https://www.nctsn.org/measures/parenting-stress-index-short-form

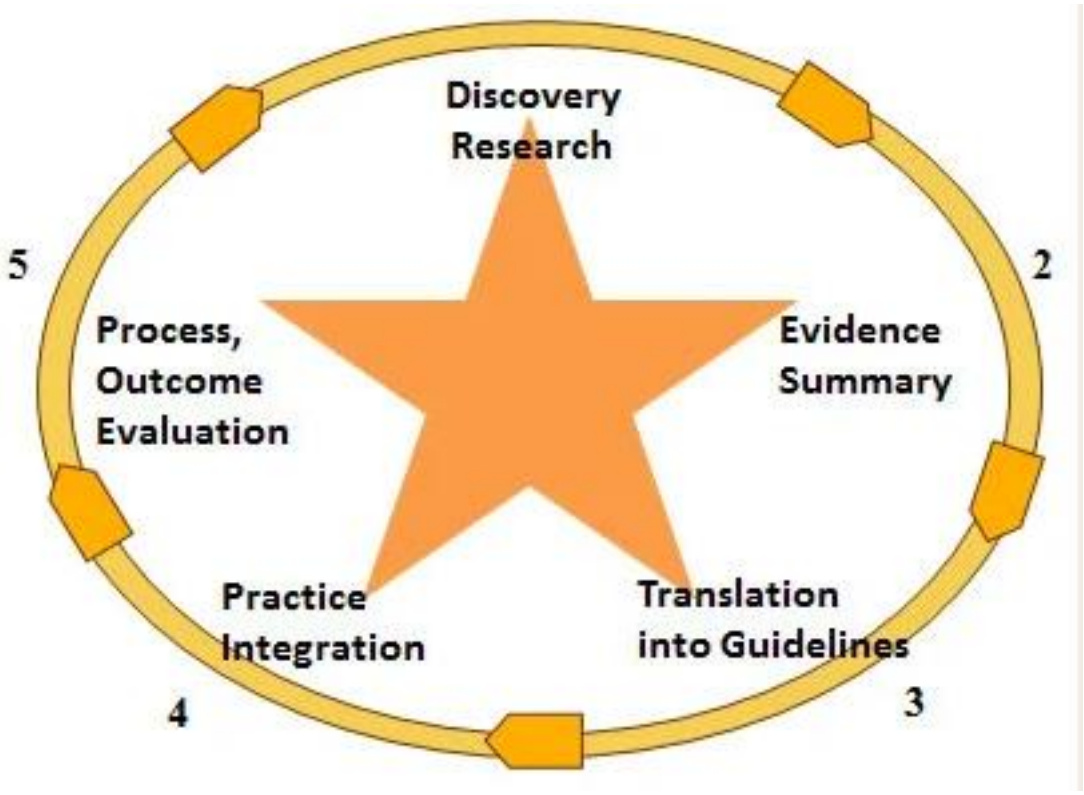
Appendix A:

Empower Action Model



Appendix B:

ACE Star Model of Knowledge Transformation



Appendix C:

Parenting Stress Index- Short Form (PSI-SF) Sample

Record/Profile Form

Richard R. Abidin, EdD

SAMPLE

Instructions:

On the inside of this form, write your name, gender, date of birth, ethnic group, and marital status; today's date; and your child's name, gender, and date of birth. This questionnaire contains 36 statements.

Read each statement carefully. For each statement, please focus on the child you are most concerned about and circle the response that best represents your opinion. **Answer all questions about the same child.**

Circle SA if you strongly agree with the statement.
Circle A if you agree with the statement.
Circle NS if you are not sure.
Circle D if you disagree with the statement.
Circle SD if you strongly disagree with the statement.

For example, if you sometimes enjoy going to the movies, you would circle A in response to the following statement:

I enjoy going to the movies. SA (A) NS D SD

While you may not find a response that exactly states your feelings, please circle the response that comes closest to describing how you feel. **Your first reaction to each question should be your answer.**

Circle only one response for each statement, and respond to all statements. **Do not erase!** If you need to change an answer, mark an "X" through the incorrect answer and circle the correct response. For example:

I enjoy going to the movies. SA A NS (X) (SD)

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PSI-4 SHORT FORM

Answer Sheet

Name _____ Gender _____ Date of birth ___/___/___

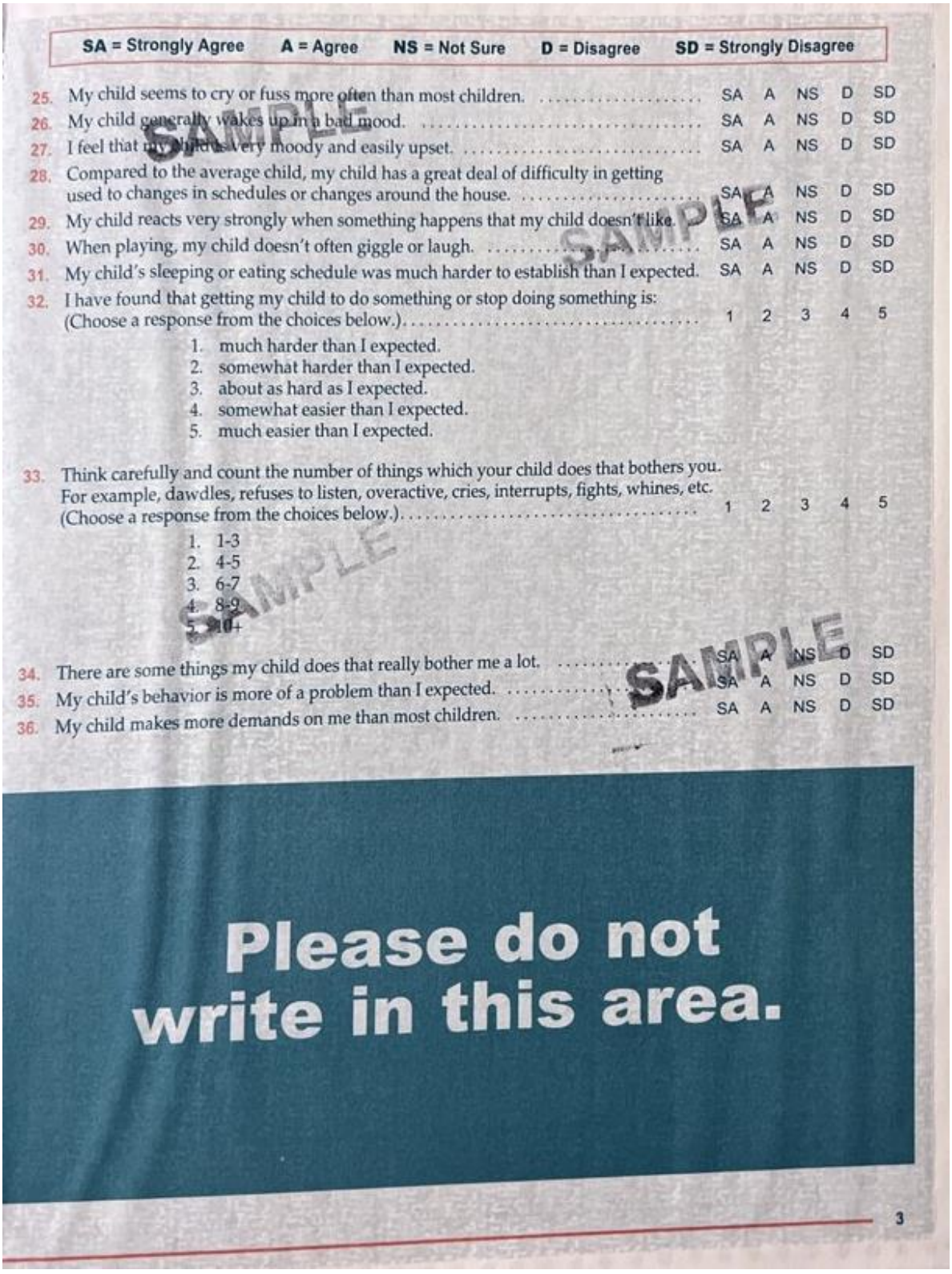
Ethnic group _____ Marital status _____ Today's date ___/___/___

Child's name _____ Child's gender _____ Child's date of birth ___/___/___

SA = Strongly Agree **A = Agree** **NS = Not Sure** **D = Disagree** **SD = Strongly Disagree**

1.	I often have the feeling that I cannot handle things very well.	SA	A	NS	D	SD
2.	I find myself giving up more of my life to meet my children's needs than I ever expected.	SA	A	NS	D	SD
3.	I feel trapped by my responsibilities as a parent.	SA	A	NS	D	SD
4.	Since having this child, I have been unable to do new and different things.	SA	A	NS	D	SD
5.	Since having a child, I feel that I am almost never able to do things that I like to do.	SA	A	NS	D	SD
6.	I am unhappy with the last purchase of clothing I made for myself.	SA	A	NS	D	SD
7.	There are quite a few things that bother me about my life.	SA	A	NS	D	SD
8.	Having a child has caused more problems than I expected in my relationship with my spouse/parenting partner.	SA	A	NS	D	SD
9.	I feel alone and without friends.	SA	A	NS	D	SD
10.	When I go to a party, I usually expect not to enjoy myself.	SA	A	NS	D	SD
11.	I am not as interested in people as I used to be.	SA	A	NS	D	SD
12.	I don't enjoy things as I used to.	SA	A	NS	D	SD
13.	My child rarely does things for me that make me feel good.	SA	A	NS	D	SD
14.	When I do things for my child, I get the feeling that my efforts are not appreciated very much.	SA	A	NS	D	SD
15.	My child smiles at me much less than I expected.	SA	A	NS	D	SD
16.	Sometimes I feel my child doesn't like me and doesn't want to be close to me.	SA	A	NS	D	SD
17.	My child is very emotional and gets upset easily.	SA	A	NS	D	SD
18.	My child doesn't seem to learn as quickly as most children.	SA	A	NS	D	SD
19.	My child doesn't seem to smile as much as most children.	SA	A	NS	D	SD
20.	My child is not able to do as much as I expected.	SA	A	NS	D	SD
21.	It takes a long time and it is very hard for my child to get used to new things.	SA	A	NS	D	SD
22.	I feel that I am: (Choose a response from the choices below.)	1	2	3	4	5
23.	I expected to have closer and warmer feelings for my child than I do, and this bothers me.	SA	A	NS	D	SD
24.	Sometimes my child does things that bother me just to be mean.	SA	A	NS	D	SD

22. 1. a very good parent.
    2. a better-than-average parent.
    3. an average parent.
    4. a person who has some trouble being a parent.
    5. not very good at being a parent.



SA = Strongly Agree A = Agree NS = Not Sure D = Disagree SD = Strongly Disagree

25. My child seems to cry or fuss more often than most children. ..... SA A NS D SD
26. My child generally wakes up in a bad mood. ..... SA A NS D SD
27. I feel that my child is very moody and easily upset. ..... SA A NS D SD
28. Compared to the average child, my child has a great deal of difficulty in getting used to changes in schedules or changes around the house. ..... SA A NS D SD
29. My child reacts very strongly when something happens that my child doesn't like. SA A NS D SD
30. When playing, my child doesn't often giggle or laugh. ..... SA A NS D SD
31. My child's sleeping or eating schedule was much harder to establish than I expected. SA A NS D SD
32. I have found that getting my child to do something or stop doing something is: (Choose a response from the choices below.) 1 2 3 4 5

    1. much harder than I expected.
    2. somewhat harder than I expected.
    3. about as hard as I expected.
    4. somewhat easier than I expected.
    5. much easier than I expected.

33. Think carefully and count the number of things which your child does that bothers you. For example, dawdles, refuses to listen, overactive, cries, interrupts, fights, whines, etc. (Choose a response from the choices below.) 1 2 3 4 5

    1. 1-3
    2. 4-5
    3. 6-7
    4. 8-9
    5. 10+

34. There are some things my child does that really bother me a lot. ..... SA A NS D SD
35. My child's behavior is more of a problem than I expected. ..... SA A NS D SD
36. My child makes more demands on me than most children. ..... SA A NS D SD

SAMPLE

Please do not write in this area.

3

Appendix D:

Approval of use for PSI-SF

Dear Makayla Gates Haas,

Thank you for contacting Dr. Abidin. Since PAR holds the Copyright to the PSI-4-SF, I am responding to your message.

If you wish to use this material in its published English or Spanish format, then you simply need to purchase the number of forms that you need. Each form is valid for one (1) administration of the test. Purchase of the forms for use in this program is permission to use them as printed by PAR. There is no license when you purchase and use published materials. I apologize that we do not provide complimentary materials.

Pricing can be found at: https://www.parinc.com/Products/Pkey/335.

Please contact me with any questions.

Best Regards,

Ms. Vicki McFadden
Senior Permissions Specialist

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Appendix E:

Demographic Form with Preamble

Over the next 8 weeks you are encouraged to attend weekly parenting-skills sessions, hosted by Makayla Haas, BSN, RN, using Hope at Home. Your participation with data collection while not required, is greatly appreciated! Prior to beginning you will be asked to create a unique identifier which you will use to sign-in for attendance and put in place as your "name" on other forms throughout the program. This unique identifier will be the first 3 letters of the name of your elementary school, and the last 3 numbers of your phone number. Ex: Westside Elementary, phone 234-9687 unique identifier: wes687. This will assure your results will remain confidential and used to assess success of this curriculum at CWC. Today, prior to starting Hope at Home, you will be asked some questions about your age, gender, race, number of children, their race, and each of their ages. You will also complete the PSI-SF pre-test. While filling this out, think about your overall parenting stress with your children. On week 8, our last week, and again 4 weeks later you will retake the PSI-SF and complete a form allowing you to express your satisfaction of this program.

Unique Identifier: _____ (ex: wes687)

Gender: M / F **Age:** _____

Race: ___ White or Caucasian ____ Black or African-American ____ Multiracial or Biracial ___Other

Number of children: _____ **Ages of children**: _____

Race of Children: ___ White or Caucasian ____ Black or African-American ____ Multiracial or Biracial _____Other

Appendix F:

Parent Satisfaction

Unique Identifier: _____ (ex: wes687)

Please answer the following questions by circling the number that best represents your thoughts.

Key: 1=Strongly Disagree 2=Disagree 3=Neutral 4=Agree 5=Strongly Agree

1. The lessons I learned through Hope at Home helped me focus on my strengths as a parent.

   1 2 3 4 5

2. I feel better equipped to focus on my strengths to help the bond between my child and me.

   1 2 3 4 5

3. I would recommend Hope at Home to every parent in recovery at ChooseWell Communities.

   1 2 3 4 5

4. Please explain what benefitted you most throughout the parenting sessions.

5. What barriers are you experiencing that's preventing you from practicing the parenting skills?

6. Have your children responded to the skills you have practiced? Please explain.

Appendix G:

The 4 Me's model

Appendix H:

Hope at Home Curriculum Timeline

Week 1: Introducing Hope at Home

- Data collection: demographics, pre-PSI, attendance

Week 2: Hope for the Future

- Data collection: Attendance

Data Week 3: Attachment

- Data collection: Attendance

Week 4: Showing Appreciation and Love

- Data collection: Attendance

Week 5: Celebrating Your Strengths

- Data collection: Attendance

Week 6: Warning Signs of Stress Overload

- Data collection: Attendance

Week 7: Learning Healthy Ways of Coping

- Data collection: Attendance

Week 8: Recognizing and Reducing Unhealthy Stress

- Data collection: Attendance, satisfaction survey, and post-PSI-SF

Week 12: Additional Data collection

- Data collection: 4-week post-PSI-SF collection

Appendix I:

Letter of Support

ChooseWell communities

To: Makayla Haas, BSN, RN

From: Leigh-Ann Yost, Executive Director

Date: September 21, 2023

Re: University of Louisville School of Nursing DNP Project Approval

We are pleased to confirm that you can complete your DNP project here with us at ChooseWell Communities. We approve the use of the Hope at Home curriculum for you to implement and collect data from to help our parents increase their resilience, coping skills, and self-care to better bond with and attach to their children.

We appreciate your partnership.

Sincerely,

Leigh Ann Yost
Executive Director
LeighAnn@Choose-Well.org
502-701-2026