



# Building on shared experiences: The evaluation of a phone-based parent-to-parent support program for helping parents with their child's substance misuse

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## HIGHLIGHTS

- Parents of a child with a SUD are motivated to provide information and emotional support to other parents.
- Being trained to provide peer support in the context of evidence-based practices was rated as highly acceptable and useful.
- Parents receiving peer-to-peer support reported improvements in their emotional distress and the use of helping strategies.
- Parent-to-parent phone-based coaching can introduce families to evidence-based practices and support.

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## ABSTRACT

**Aims:** To evaluate the feasibility and acceptability of a phone-based parent-to-parent support program, in which parents who have had children with substance use problems provided support and guidance to other parents seeking help about their child's substance misuse.

**Method:** 228 parents completed a 2.5-day coach workshop and 6-months of ongoing training and support in the Invitation to Change Approach (ITC), a program blending evidence-based strategies for addressing substance use disorders. Trained parent coaches provided support and guidance to 278 parents for up to 8 weeks. We evaluated the coach trainees' satisfaction with the training program and pre-post differences in self-care and the use of communication and behavior management strategies among parents who called the helpline.

**Results:** The coach training program was rated as very satisfying, useful, and coaches would recommend the training to other parents. Among parents enrolled in the coaching program, a significantly greater proportion reported improvements on a majority of the survey items (e.g. a decrease in depression and better communication with child).

**Conclusions:** Remote parent-to-parent coaching appears promising for providing emotional and evidence-based informational support to family members parenting a child with substance use problems.

## 1. Introduction

Substance misuse among adolescents and young adults poses a significant challenge for many American families as it impacts the psychosocial functioning of both the substance user and concerned family members (Toumbourou, Blyth, Bamberg, & Forer, 2001). Approximately 40% to 50% of adolescents have used illicit substances sometime during their life (Johnston, O'Malley, Miech, Bachman, & Schulenberg, 2014), 11.4% meet criteria for a lifetime substance use

disorder (SUD) (Merikangas et al., 2010) and among young adults (i.e. 18 to 24 years), approximately 38.4% and 23.2% report binge drinking and illicit drug use, respectively (SAMHSA, 2016). Evidence-based protocols developed for addressing substance misuse among adolescents and young adults have included the broader family context as part of the intervention (Liddle, Dakof, Henderson, & Rowe, 2011; Robbins et al., 2011). However, there has been less emphasis on directly assisting and supporting affected family members with evidence-based protocols and strategies (cf. Blyth, Bamberg, & Toumbourou, 2000;

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Orford, 1994). Evidence suggests family members can significantly influence the likelihood that their loved one will seek (Roozen & de Waart, 2010) and benefit from treatment (Brigham et al., 2014), as well as improve their own psychosocial functioning when they are provided with evidence-based coping skills, helping strategies, and support (Miller, Meyers, & Tonigan, 1999; Toumbourou et al., 2001).

A majority of family members will not come into contact with evidence-based strategies for supporting themselves or helping their loved one with mental health or behavioral disorders (Ilgen et al., 2011). Economic, geographical, and professional barriers can restrict the type of guidance, support, and services that families receive. Thus, identifying delivery systems that can augment the limited reach of traditional support services for families affected by SUDs can address an important public health need. To this extent, there has been an historical interest (e.g., Martin & Shepel, 1974) and a growing evidence base (Acevedo-Polakovich, Niec, Barnett, & Bell, 2013), highlighting the acceptability of bringing individuals with no specialized professional mental-health counseling or medical training into the broader network of health care providers in order to extend the reach of health services. This model has come under the rubric of community health workers (Cherrington et al., 2008) natural helpers (Acevedo-Polakovich et al., 2013), paraprofessionals (Calzada et al., 2005), and lay-counselors (Dewing et al., 2013). This strategy has been successful in addressing a range of mental (Neuner et al., 2008) and behavioral health issues (Jelalian et al., 2014). Of most relevance, evidence suggests non-professionals can help implement training for parents that focuses on increasing positive parent-child interactions and establishing more effective behavioral management strategies (Brotman et al., 2011), which are also key components in family focused interventions for addiction (Liddle et al., 2001).

Peer Recovery Support Services (PRSS) align with the natural helper paradigm and offer a promising framework for bringing individuals into contact with evidence-based strategies and support (White, 2010). They can encompass services for individual, family, and/or social networks and may include activities such as mentoring, coaching, and education. However, in contrast to other clinical intervention or support paradigms (e.g. lay-counselor), experiential knowledge (i.e. truth learned from personal experience, Borkman, 1976) is an organizing and central component in this model (White, 2014). PRSS are being reemphasized as an important component of the support scaffolding available to families and individuals affected by addiction (White & Evans, 2013). Parent-to-Parent (PTP) programs, a conceptual cousin of PRSS, connect parents of children with physical, emotional, or behavior disorders with veteran parents (i.e. parents who have “been there”) to facilitate informational, emotional, and affirmational support (Ireys, Chernoff, Stein, De Vet, & Silver, 2001; Russa, Matthews, & Owen-DeSchryver, 2015). PTPs have been utilized in programs that address chronic health or emotional conditions among children (Goodwin & Mickalide, 1985; Kutash, Duchnowski, Green, & Ferron, 2011; Preyde & Ardal, 2003) and have demonstrated efficacy in improving coping skills, reducing stress, and promoting helping-seeking among parents who received this support (Acevedo-Polakovich et al., 2013). The opportunity to speak with other parents who have had similar experiences is a key component of PTP programs and is the primary reason parents have sought out this type of assistance (Santelli, Turnbull, Marquis, & Lerner, 1995). While PTP programs have often been implemented in the context of face-to-face interaction models (Nicholas & Keilty, 2007; Vandereycken & Louwies, 2005) they are also effective when delivered by telephone (Ireys & Sakwa, 2006; January et al., 2015) thus reducing some of the logistical barriers to their implementation (Ainbinder et al., 1998). However, to date the potential utility of PTP programs for providing support and guidance on the availability and use of evidence-based strategies for parents trying to address substance misuse among their children has received little attention.

This report presents an evaluation of a phone-based PTP support program with national reach. Parents who have had children with SUDs

were introduced and trained in the Invitation to Change Approach (ITC; CMC, 2016), a program that includes concepts and strategies incorporated in several evidence-based interventions for SUDs (i.e. Community Reinforcement and Family Training (CRAFT; Smith & Meyers, 2004), Motivational Interviewing (MI; Miller & Rollnick, 2013), and Acceptance and Commitment Therapy (ACT; Hayes, Stroschal, & Wilson, 2012). In turn, these parents provided time-limited support and guidance in the use of these strategies in the context of a PTP helping model via phone conversations to other parents seeking help and support around their child's substance misuse. The specific objectives of this project were to: (a) assess the feasibility of implementing such a service in the community, (b) assess the acceptability of the training and coaching service among those being trained as coaches, and (c) assess the acceptability and potential helpfulness of remote parent-to-parent support among parents utilizing the program.

## 2. Methods

### 2.1. Participants and procedures

#### 2.1.1. Parent coaches

Potential coaches were recruited via collaborative relationships between the Partnership for Drug-Free Kids (PDFK) and parent support and advocacy groups throughout the continental United States or parents contacting either of the two training organizations directly (CMC or PDFK). Community organizations were informed of the program and the need for coaches prior to the scheduling of a training in a particular location. Parents who volunteered and met selection criteria ( $n = 228$ ) to participate in the coach training protocol completed a 2.5-day workshop and were offered 12, 1-h biweekly support calls over six months following the workshop (a total of 32 h of training). Workshop trainings were conducted over a 4-year period (from 2014 to 2018) in communities across the United States. Program staff interviewed interested parents prior to workshop attendance and employed the following selection criteria: (a) the parent expressed interest in being a coach, (b) the parent reported direct experience of having a child with an SUD and being a minimum of 12-months past the initial crisis event (e.g. child identified as having an SUD, overdose, arrest); if their child had died, a minimum of 18 months had to have passed since the event and there was an extensive discussion about possible triggering situations while coaching; (c) the parent expressed interest in learning about evidence-based strategies for helping families who are struggling with SUDs. Potential participants were not able to volunteer if they evidenced an untreated psychiatric disorder (e.g. bipolar; schizophrenia), a current SUD (excluding tobacco use), or were unable to commit to the training and coaching timelines and requirements.

#### 2.1.2. Training workshop and support calls for parent coaches

Training workshops included didactic instruction, experiential exercises, and in-vivo practice of the behavioral and communication skills in the Invitation to Change Approach (CMC, 2016). Eleven doctoral level psychologists with an average of 15 or more years of experience in treating SUDs, trained in each of the component therapies (i.e. CRAFT, MI, ACT) and their use in the ITC, conducted the workshops and post-workshop support training calls. During the workshop training (20 h over 2.5 days), participants were introduced to the concepts of reinforcement and learning as central components of substance use, the use of operant conditioning for increasing and decreasing behavior (i.e. reinforcement and punishment), ambivalence as a normal part of the process of change, the role of being willing to stay connected to valued activities in the presence of emotional discomfort, the importance of practice in learning these new skills, and the role of self-care as a key helping strategy. Further, participants practiced the communication (open questions, affirmations, reflective listening, summary statements, and asking permission) and behavioral strategies during the workshop to facilitate their learning and use during the coaching calls. Coach

trainees could participate in 12 bi-weekly support calls with the trainers to discuss these concepts in more detail and review how they were being applied in ongoing coaching calls.

### 2.1.3. Parent callers

Parents who called a national helpline spoke with a trained phone counselor at PDFK, who assessed the needs of the caller (e.g. information only, guidance to other resources, coaching). Parents who were interested in receiving phone coaching were provided information on the program and an invitation to opt into the service. Parent callers were not offered participation if they reported ongoing domestic violence, reported significant psychiatric difficulties themselves, or their child was reported to recently have experienced an overdose. Guidance to other support services or resources were offered in these situations. All parent callers were required to sign a coaching agreement and officially opt into the coaching service prior to working with a parent coach. Callers were informed in the agreement that they were to receive a time-limited service that had the goal of providing support, information, and discussion of evidence-based strategies that could help them and their affected loved-one. Callers were informed that these discussions would be with another parent who had a shared experience and were explicitly notified that this was NOT a psychotherapy service.

### 2.1.4. Coaching service

Callers who opted into the coaching program were paired with a parent coach based on time zone compatibility (coaches and callers were to be no more than one time zone apart for ease of scheduling). There were no other matching criteria employed (e.g. same substance issue or age of child) in the coaching assignments. Coaches were instructed to reach out to a caller a maximum of three times. If contact was not achieved after three attempts the parent was notified they could call the helpline if they would like to discuss participating in the program at a better time for them.

Each coaching episode was to consist of 5, approximately 60-min weekly phone calls, to be conducted over a maximum 8-week period of time. During the calls, coaches were to employ active listening skills, assist parents in thinking about their own self-care, how the communication and behavioral strategies employed in the ITC could be applied to their situation, and when needed, provide information about support services located in their community.

### 2.1.5. Outcome measure and analysis plan

Individuals who participated in the coach-training workshop completed a survey to assess their overall satisfaction with the quality of the training, their satisfaction with the practice materials, the extent to which they believed their understanding of the evidence-based concepts was enhanced, and the extent to which they would recommend the training to another parent. Coach trainees were asked to rate the quality of their training and their satisfaction with the training materials on a 5-point Likert scale ranging from (1) "Very Satisfied" to (5) "Very Dissatisfied". For the items assessing knowledge enhancement and the likelihood of recommending the training to others, participants responded on 5-point Likert scale ranging from (1) "Strongly Agree" to (5) "Strongly Disagree".

Parents who called the helpline and opted into the coaching program completed an 18-item survey before speaking with a coach. They were asked to respond to questions that assessed the frequency of self-care behaviors, the extent to which they used positive and negative communication strategies with their child, as well as the behavioral strategies of positive reinforcement and natural consequences during the 30-days prior to the assessment. Parents were asked to select one of four response options for each survey item: "None", "A Little", "Somewhat", or "A lot". Following the end of a coaching episode, a member of the research staff called each participant to administer the same survey items to assess the frequency with which the caller engaged in the strategies in the 30 days prior to the follow-up assessment.

The goal was to administer the follow-up survey approximately 40 days following the end of the 8-week coaching period. Participants were also asked about their experience with the coaching program and their statements were recorded as qualitative information.

For analytical purposes each item response was collapsed into one of two categories "none/a little" and "somewhat/a lot." Changes in the distribution of responses for each survey item across the two assessment periods (i.e. the before coaching survey and the after coaching survey) were evaluated using the McNemar test statistic. A Bonferroni correction was applied as a conservative approach given the multiple comparisons conducted in this study (per comparison corrected alpha = 0.003).

## 3. Results

### 3.1. Workshop training ratings

Approximately 86% of the coach trainees were mothers (fathers constituted 14% of the coach trainees), and 69% reported that their sons were the affected family member (daughters 19%; other family members 12%). Regarding substance use status of their child, 66% reported their loved one was in recovery, 30% had a loved one continuing to struggle with an active SUD, and 15% reported they had a child lose their life in the context of a SUD. On average, the trainees reported finding the quality of the trainings very satisfying ( $M = 1.2$ ,  $SD = 0.52$ ; 83% very satisfied, 15% satisfied) and the training materials very useful ( $M = 1.3$ ,  $SD = 0.48$ ; 74% very satisfied, 22% satisfied, 2% neutral, 1% dissatisfied).

Trainees also strongly agreed with the statements that their understanding of the evidence-based strategies and concepts was enhanced as a result of the training ( $M = 1.3$ ;  $SD = 0.51$ ; 75% strongly agree, 23% agree, 2% neutral) and that they would recommend the training to other parents ( $M = 1.1$ ;  $SD = 0.43$ ) with approximately 96% of the trainees reporting strongly agreeing or agreeing with the statement (89% strongly agree, 7% agree, 4% neutral).

### 3.2. Before and after coaching surveys

A total of 279 parents called the helpline, opted into the coaching program, and completed a baseline survey between January 1, 2017 and April 31st, 2018. Among all the enrollees, callers spoke with their coach on the phone an average 2.7 times ( $SD = 2.3$ ; range 0–8 calls). However, approximately 30% of the enrollees had no calls with a coach; 53% had 3 or more calls. Among those callers who had at least one contact with a coach, the average number of calls was 4.0 ( $SD = 1.7$ ; range 1–8). [Table 1](#) presents the characteristics of the all parent callers, the substance of primary concern, and characteristics of the child they were calling about. As noted in [Table 1](#), most callers were from the Northeast and reported their child was living at home. Mothers accounted for the majority of callers and they were more likely to be calling about their sons. The majority of callers were concerned about their adolescent or young adult child's use of marijuana, with opiate use being the second most frequent substance of concern.

Follow-up surveys were obtained for 110 of the parents opting into the coaching program (39.4% of the total sample; 47% of those who spoke with a coach at least once). The median number of days to follow-up was 65 days (Interquartile range = 40 to 104 days). Analyses were conducted to compare the callers who completed a follow-up survey ( $n = 110$ ) to those who were lost to follow-up ( $n = 169$ ). No significant differences were noted on any of the demographic characteristics: gender of the caller  $\chi^2 = 0.05$ ;  $df = 1$ ;  $p < .82$ , relationship to child  $\chi^2 = 4.4$ ;  $df = 5$ ;  $p < .51$ ; geographical region  $\chi^2 = 3.2$ ;  $df = 3$ ;  $p < .38$ , gender of the child  $\chi^2 = 0.16$ ;  $df = 1$ ;  $p < .70$ , child's age group  $\chi^2 = 2.1$ ;  $df = 2$ ;  $p < .35$ , child's living arrangement  $\chi^2 = 1.4$ ;  $df = 1$ ;  $p < .23$ , or the substance of primary concern  $\chi^2 = 6.1$ ;  $df = 7$ ;  $p < .54$ . However, those who were lost to follow-up completed less

**Table 1**  
Characteristics of the parent callers who enrolled in the coaching support program.

Variable	
Relationship to child being called about (n).	
Mother	88% (245)
Father	8% (21)
Other	2% (4)
Gender of child parent is calling about.	
Male	69% (191)
Female	29% (81)
Age of child parent was calling about.	
13–17	43% (120)
18–24	40% (112)
25+	14% (38)
Caller's primary substance of concern.	
Marijuana	60% (168)
Opioid	15% (41)
Alcohol	7% (19)
Cocaine/stimulants	6% (17)
Benzodiazepine/sedatives	6% (17)
Other	3% (9)
Living arrangements of child being called about	
At home	77% (214)
Not at home	18% (51)
Caller's geographical region	
Northeast	56% (155)
South	14% (39)
Midwest	12% (32)
West	17% (46)

Note: Percentages do not total 100 due to missing data.

coaching calls on average (M = 2.1 calls (SD = 2.2) vs M = 3.6 calls (SD = 2.3);  $t_{(272)} = -5.7, p < .001$ ) and reported engaging in self-care less frequently before receiving coaching ( $\chi^2 = 8.5; df = 1; p < .005$ ) compared to callers who completed a follow-up assessment. No significant differences were demonstrated between the groups on any of the other baseline survey items.

Table 2 presents the percentage of parent callers reporting changes in the communication, behavioral, and attitudinal variables across before and after coaching assessments. Changes were characterized as being either in an improved direction or a worsened direction. McNemar tests directly compared the proportion of individuals changing in the improved direction against the proportion of individuals reporting changes in a worsened direction (of note, participants demonstrating no change cannot contribute to the analysis of pre-post

**Table 2**  
Percentage of parent callers 'improving' and 'worsening' based on changes across the before and after coaching assessments.

Survey item	Improved (n)	Worsened(n)	McNemar test exact probability
Had useful discussions with my child about their substance use ("useful discussions")	19% (20)	19% (20)	1.0
Taken concrete steps to assist my child in getting help for their substance use. ("concrete steps")	20% (20)	17% (17)	0.74
Collaborated with other family members to support my child ("collaborated family")	19% (20)	13% (14)	0.39
Pursued interests of yours or looked for ways to take of self ("self-care")	21% (22)	13% (14)	0.24
Discussed my child's struggles with other people in my life ("isolation")	21% (22)	10% (10)	0.050
Been able to focus on the interests of other family members besides my child ("family self-care")	22% (23)	8% (8)	0.011
Believed there was nothing that could be done to help situation ("hopefulness")	22% (24)	8% (8)	0.007*
Spent time worrying about how to help ("worry")	24% (26)	0% (0)	< 0.001*
Been able to compliment my child on their positive actions ("positive reinforcement")	25% (26)	6% (6)	0.001*
Felt too frightened to do anything ("frightened")	25% (25)	5% (5)	< 0.001*
Picked good times to talk to my child about their struggles ("communication timing")	28% (28)	9% (9)	0.003*
Allowed my child to experience the negative consequences of their substance use ("allowed natural consequences")	31% (30)	1% (1)	< 0.001*
Developed a better understanding of my child's substance use ("understanding SU")	35% (36)	12% (12)	0.001*
Been unhappy/depressed ("happy")	38% (41)	7% (7)	< 0.001*
Found it difficult to make decisions about how to help my child ("decisiveness")	40% (40)	7% (7)	< 0.001*
Started to believe are things are beginning to get better with my child ("hopefulness")	45% (48)	5% (5)	< 0.001*
Gotten into arguments with child about their substance use ("arguments")	40% (42)	5% (5)	< 0.001*
Felt confident in my handling of the issues surrounding child's substance use ("confidence")	48% (50)	4% (4)	< 0.001*

\* Significant at the Bonferroni adjusted alpha = 0.003.

**Table 3**  
A sample of caller statements about their experience of the PTP program.

"Coach was really nice, classy. She was very engaging, nice to have the space to talk to someone who didn't have an agenda...."

"Coach has been great, fantastic. She helps keep me thinking positive and turns everything into a positive. She has been the best resource out of any of the programs we've tried. It has been so beneficial to me"

"Coach was completely amazing. I feel fortunate that the whole program was there for me. I have recommended this program to many others. The parent coach was very well trained and I wished the parent coach was my neighbor"

"I felt like I had a puzzle to fix and she helped me fit in the pieces. I loved my coach. I wish it could go on forever. It gave me a situation that was similar"

"My parent coach was incredibly helpful and made me feel that I am not losing my mind. Professional, yet caring, he gave good advice, listened and remembered from week to week all of the issues at hand. So, so grateful for the support he offered"

"Coach was absolutely wonderful. She was supportive, helpful and asked me questions to make me think critically about how to approach situations"

"My advisor was very compassionate, helpful, and understanding. She gave me all the support and guidance I needed during this difficult time in our lives. She recommended a wonderful book that helped me a lot. I really appreciated her "

"The parent's support network as well as this whole program has been very helpful to my husband and I who felt lost and overwhelmed! Thank you for the guidance and support. We're very grateful...Thank you!"

"My coach was wonderful. She gave such amazing advice—better than the therapies I've had before..... I would have loved to even stay longer in the program"

"My coach was most patient and informative in a very caring and positive manner. She gave me tools to work through issues in ways I never thought of and I am now able to look at certain situations differently"

assessment differences thus these tests assess differences only among those demonstrating change). Results indicated a significantly greater proportion of parent callers reported changes in the improved direction compared to those reporting a worsening on 12 of the 18 survey items. Specifically, a significantly greater proportion of callers reported improvements on the items assessing the belief that things are getting better, a reduction in arguments with their child, increased confidence in handling the situation with their child, improved mood, the use of verbal reinforcement, and allowing for natural consequences associated with their child's substance misuse. No differences were noted on the items assessing if they had taken concrete steps to help their child, pursued personal interests and self-care, and had useful conversations with their child about their substance use.

A sampling of qualitative statements about the experience of callers is presented in Table 3. Most of the quotes speak to the positive interaction callers had with their parent coach. Further, the statements indicated many callers found utility in speaking with another parent who offered information and resources that could be of help.

#### 4. Discussion

Parents who called a national helpline and opted into a parent-to-parent coaching program reported significant improvements on a majority of survey items assessing emotional health, hopefulness, having an understanding of their child's substance use, and the frequency with which evidence-based communication and behavioral strategies were employed. These improvements were reported in the context of the ideas and practices incorporated in the ITC approach, which includes components of CRAFT, MI, and ACT, being presented to callers by a peer coach through parent-to-parent phone-based discussions. Moreover, parents who volunteered to be trained as a coach found the training very useful and parent callers reported a high degree of satisfaction with their coach and the services provided. These findings provide initial support that a program offering coaching by trained peers can provide an acceptable and feasible platform by which evidence supported concepts are transmitted to and utilized by other parents seeking assistance and guidance on how to respond to their child's substance misuse. Similar to studies with parents of children with other chronic disabilities (Shilling et al., 2013), the present findings suggest parent-to-parent coaching services based on a shared experience foundation can play an important role in providing emotional and informational support (e.g. knowledge and skills). Further, a phone-based platform, an acceptable delivery platform demonstrated in other parent-to-parent programs (Kutash et al., 2011), allowed families to connect and talk with other parents independent of their geographical location. The remote accessibility of this service can potentially mitigate the problems associated with limited availability of services and support within a local community. Overall, the present findings suggest the continued investigation of this novel dissemination process, whereby parent-to-parent discussions of evidence-based concepts and strategies may impact families who may otherwise not come into contact with this support and information, is warranted.

The proportion of parents reporting an increase in the frequency of useful discussions with their child about their substance use ("useful discussions"), taking concrete steps to assist their child in getting help for their substance use ("concrete steps"), collaborating with other family members ("family collaboration"), and pursuing personal interests and self-care ("self-care") did not significantly differ from the proportion of parents reporting a decrease in the frequency of these activities. It is unclear why the coaching program was not associated with differential changes on these outcomes. Unilateral treatment programs offered by professionals have demonstrated increased treatment engagement by affected loved ones within 4 to 6 sessions (Roozen & de Waart, 2010). Thus, the shorter duration of the peer-led coaching service may have mitigated against finding a significant effect on the taking of "concrete steps" outcome in this study. In addition, decreases in the frequency of these variables may have reflected a more measured approach to helping based on the skills and strategies being offered rather than an iatrogenic effect of the coaching service. For example, while the proportion of parents reporting increases or decreases in the frequency of "useful discussions" did not differ, a significantly greater proportion of parents reported increases in the "communication timing", "verbal reinforcement", and decreases in "arguments" variables. Thus, changes in *how* communication skills were utilized by parents may have impacted the *frequency* of substance use specific conversations. It is important to further explore the limits of a time-limited peer-led service and understand the factors influencing changes on these outcomes in order to help guide future changes in the content and strategies offered to parents to address these issues.

This pilot study sought to investigate whether a parent-to-parent peer-coaching program utilizing evidence-supported concepts of change would provide an acceptable and feasible platform for providing emotional and informational support around the issues of parenting a child with a substance use problem. It was important to evaluate acceptability and feasibility among both the parent coach trainees and the

parents who sought this service. Individuals who had the experience of parenting a child with a SUD demonstrated significant interest in helping other parents. The parents who volunteered to be coaches participated in a 20-h weekend training program and 6-months of ongoing support and training (i.e. 12 h) to learn evidence-based communication and behavioral concepts and strategies for themselves and to share these with other parents. The coaches completing the training rated their experiences highly satisfying and a significant proportion (96%) reported they would recommend the training to other parents. These results indicate that the present training could be successfully implemented in community settings and that it was found to have a high degree of acceptability among non-professionals. Importantly, the time volunteer parents invested in receiving the training and conducting the coaching conversations highlighted the importance of this program for them. Evaluations of other peer support programs for parents with children having chronic disabilities have emphasized the bi-directional impact of such services. Specifically, parents providing support and sharing their experiences have found that the role of mentoring or coaching validates their own journey, can increase their self-worth, and enhances their level of support (Shilling et al., 2013). These benefits and the bi-directional nature of support of peer-led services may be an important component in the further development and sustainability of parent-to-parent support networks as a framework for extending the reach of evidence-based principles and strategies to families affected by SUD.

Parents from across the country called the free helpline and opted into the coaching program when informed of the service. Qualitative statements from parents receiving coaching and completing a follow-up assessment suggested a high level of acceptability of this service. The opportunity to talk with another parent with lived experience who was also knowledgeable about useful skills and strategies was appreciated and seen as a positive experience. These subjective accounts aligned with previous studies indicating that speaking with a parent with a shared experience is the primary reason parents seek out this type of assistance (Santelli et al., 1995). The present study builds on the work of other parent-to-parent support programs and highlights the feasibility and extension of this platform for addressing the needs of parents of children with SUDs. Specifically, extending the parent-to-parent support model to SUDs may simultaneously address the limited social support and low penetrance of evidence-based strategies in communities when parents are seeking help around their child's substance misuse.

Similar to studies of psychotherapy utilization where the modal number of sessions is one (Gibbons et al., 2011), a notable minority (approximately 30%) of the parents seeking assistance only spoke with a helpline worker during the initial phone call in this process and never connected with their parent coach even after numerous attempts to schedule a phone coaching session. A number of personal and logistical factors may have contributed to this finding. However, while the phone-based platform of these services offered a readily available and practiced communication vehicle, which can facilitate connections over long distances, it can also introduce other logistical challenges (Ainbinder et al., 1998), such as coordinating two schedules in the context of busy lives, sometimes across different time zones. Thus, the constraints associated with this communication platform may have also contributed to the observed attrition rate. Future research assessing the barriers to utilizing phone-based services and the use of alternative communication platforms could offer an important step in the evolution and reach of this parent-to-parent support service. For example, social media and texting services may provide a broader and more flexible framework for facilitating peer-to-peer interactions. These platforms are currently being utilized for addressing other mental health and behavioral disorders and appear to offer a promising alternative to and extension of traditional support technologies (Muench, van Stolk-Cooke, Morgenstern, Kuerbis, & Markle, 2014; Wagner, Horn, & Andreas, 2014).

The present findings should be viewed in the context of certain limitations. First, this was not a randomized clinical trial, so parents who received coaching were not compared to parents receiving another type of service (e.g. self-help group only; waitlist control). Thus, the changes demonstrated over the course of the coaching program could have been influenced by other factors. However, the primary goals of the pilot project were to ascertain the acceptability and feasibility of this type of support. This study demonstrated that individuals were willing to be trained in the skills and strategies of evidence-based protocols to be a coach, and parents found the opportunity to speak with a peer a useful and positive experience. Second, rigorous analyses of skill acquisition by the coaches and parent callers were not conducted in this project. Studies suggest peer-delivered MI can be effectively implemented, although peer specialists, as well as professionals, may acquire some MI skills better than other skills (Mastroleo, Turrisi, Carney, Ray, & Larimer, 2010). Future studies that specifically focus on the training parameters utilized to train parent coaches and assess how parent callers are experienced by their affected loved one are important next steps. Third, a majority of the parents seeking coaching assistance were concerned about their child's use of marijuana and were calling from the Northeast. Thus, the generalizability of the present findings may be limited to the extent that the utility of peer support differs across substances and geographical region. Fourth, follow-up rates for the full sample hovered close to 40% (47% among those receiving at least one coaching call). To the extent callers lost to follow-up would have reported less improvement, the present results may be an overestimate of the changes over time. However, callers lost to follow-up also reported having fewer coaching calls. Analyses (exploratory, not presented) indicated improvements on some of the outcome variables (i.e. confidence, understanding substance abuse, verbal reinforcement) were more likely to be demonstrated among parents receiving three or more calls. Thus, the loss to follow-up may have limited our ability to detect more fine-grained "dose-response" associations. Addressing loss to follow-up is a critical issue in longitudinal designs and increasing the follow-up rate in future investigations of this national program is key to ascertaining an estimate of the program's efficacy. Strategies such as providing incentives for completing assessments may offer a possible avenue to address this issue.

Family support services for addressing addiction are limited (Olmstead, Abraham, Martino, & Roman, 2012). While self-help programs can be an important component of the support offered to families affected by substance use; they are often the only services suggested and do not bring family members into contact with evidence supported concepts and skills. Further, few treatment programs provide evidence-based protocols to help family members employ the communication and behavioral strategies that can assist them and their loved one throughout the recovery process (Olmstead et al., 2012). The results of this investigation suggest a parent-to-parent support program that includes conversations about evidence-based concepts and strategies in the context of a shared experience may be an important framework for providing emotional, affirmational, and informational support to families as they navigate the world of parenting a child with substance use problems.

#### Declaration of Competing Interest

All authors declare that they have no conflicts of interest.

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