



Module VII: Identifying and Assisting Children of Substance Abusing Parents

I. Learning Objectives

At the end of the training, health care professionals will be able to:

- Cite evidence documenting the large number of children and adolescents whose parents have substance use disorders.
- Discuss the concept of resilience.
- Discuss the impact of parental alcohol or other drug use disorders on children and adolescents.
- Ask about concerns and discuss parental substance use disorders with patients and families.
- Screen for adolescent substance use disorders.
- Discuss the importance of cultural influences in working with children of substance abusing parents.

II. Chronology

- 45 Minutes.
- Strategy: slide lecture focusing on the impact on children from substance abusing families, including, consequences, clinical presentations, and how health care professionals can be helpful in fostering resiliency and a videotape of an adult who grew up with an alcoholic father.
- 1 hour and 15 Minutes.
- Strategy: small group skill session in which each participant will practice: 1) interviewing a child/adolescent to identify a family member with a substance abuse problem, using the case provided in this module; 2) screening a teenager regarding substance use, using the case provided.

III. Facilitators Materials

- Slides-hardcopy or on disk, projector and screen
- Slide narrative with case studies and appendices
- Copy of videotape of an adult who grew up in a family with an alcoholic father

IV. Participant Materials

- Participant handout summarizing the information about Identifying and Assisting Children of Substance Abusing Parents plus the Case Studies and Appendices

V. Contents of Appendices

- Core Competencies For the Involvement of Health Care Providers in the Care of Children and Adolescents in Families Affected by Substance Abuse
- Algorithm: The most important question some NEVER ask
- Helping Patients and Families Change
- Resources for Children and Families

Module VII: Identifying and Assisting Children of Substance Abusing Parents

This handout is organized in the order of the Module VII Slides. Following the number and title of each slide are notes that the presenter can use to educate the participants about each area of the material.

Slide 1: Module VII: Identifying and Assisting Children of Substance Abusing Parents –
This is the Title slide for Module VII.

Slide 2: Learning Objectives – At the end of the training, health care professionals will be able to:

- Cite evidence documenting the large number of children and adolescents whose parents have substance use disorders.
- Discuss the concept of resilience.
- Discuss the impact of parental alcohol or other drug use disorders on children and adolescents.

Slide 3: Learning Objectives (continued)

- Ask about concerns and discuss parental substance use disorders with patients and families.
- Screen for adolescent substance use disorders.
- Discuss the importance of cultural influences in working with children of substance abusing parents.

INTRODUCTION

Slide 4: Children Suffer from Parental Substance Abuse

Alcohol and drugs constitute major problems, not only for the individuals who suffer from substance use disorders, but also for the family, friends and society that surround them. Children can be the silent victims of parental substance use problems. Grant (2000) found that approximately 1 in 4 children younger than 18 years of age (28 million) live in a household where they are exposed to familial alcohol abuse or dependence. Moreover, 43% of U.S. children, sometime in their lives, have lived with one or more adults with a substance abuse disorder. These figures do not include children who are homeless or who live with families that are impaired from other psychoactive drugs.

Slide 5: Families

Children who are from families, where there are substance use disorders (SUD's), are at risk for biological, developmental, psychological, behavioral, health or social consequences.

RISK/PROTECTIVE FACTORS AND RESILIENCY

Slide 6: Risk Factors

Risk factors are indicators for potential problems and, subsequently, occur more often for those who develop SUD's. The more risk factors children experiences, the more likely they will develop SUD's or other serious consequences (NIDA, 1997).

Slide 7: Some at High Risk, Don't Develop Substance Use Disorders

Although considered high risk, many children of alcoholics or other substance-abusing parents grow up without developing substance use disorders or other serious consequences. Why or how this occurs, is not fully understood. The Center for Substance Abuse Prevention (2000) suggests that protective factors help shield a child from the risk of having parents with SUD's. Although there may be an association between protective and risk factors, the relationship is not causal in nature. The science fundamental to risk and protective factors is still in its infancy. It has just begun to explain the highly interactive nature of biological and environmental variables as they play out in the developmental life course. Protective factors may be situation specific and what could be protective for one child may not be protective for another.

Slide 8: Protective Factors

Protective factors are the presence of positive influences, not merely the absence or opposite of risk factors (NIDA, 1997). Protective factors are not the opposite of risk factors and are not directly associated with a given negative outcome (e.g., alcohol addiction). They become meaningful only in the presence of some risk factor or set of risk factors. An example of a protective factor is having a caring, supportive adult in a child's life. While the presence of a supportive adult is in itself unrelated to whether that child develops an addiction, in the presence of alcoholic parents, the caring adult buffers or moderates the effects of the family addiction on the child.

Slide 9: Protective Factors (continued)

Examples of protective factors in various areas of a child's life are:

- 1) **Individual**—positive sense of self and good problem solving skills;
- 2) **Family**—high level of warmth, absence of severe criticism, high parental expectations, clear rules, and maintenance of family rituals

Slide 10: Protective Factors (continued)

More protective factors for children:

- 3) **Peer**—involvement with positive peer group activities and norms,
- 4) **School**—high expectations, clear standards and rules for appropriate behavior.

Slide 11: Protective Factors (continued)

More protective factors for children:

- 5) **Community**—caring, support and opportunities for participation and;
- 6) **Society**—counteradvertising and decreased substance accessibility (CSAP, 2000).

Slide 12: Resiliency

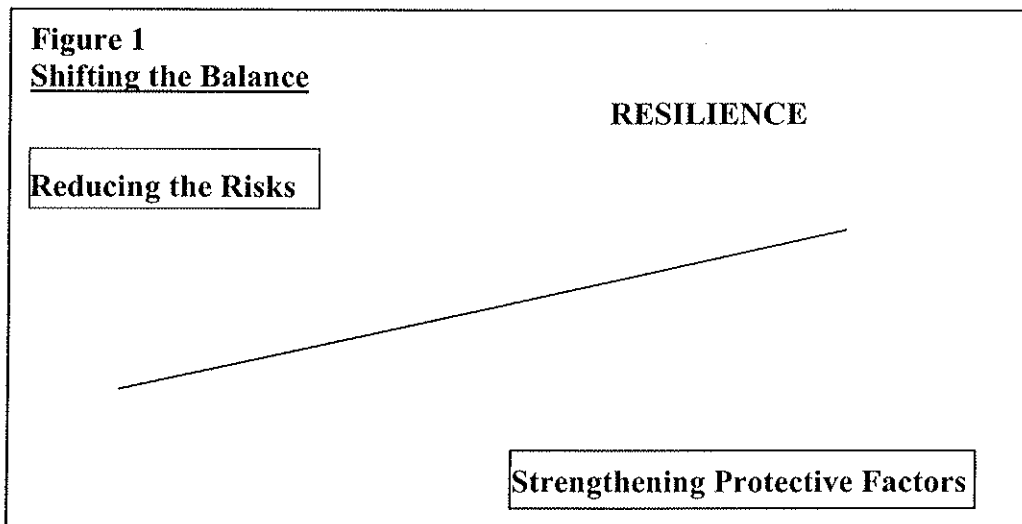
Resiliency can be defined as successful adaptation despite exposure to risk and adversity (Wolin & Wolin, 1995). Resilient individuals may be buffered from a variety of risks by a set of protective factors. Research on resiliency and protective factors explores the healthy, positive aspects of life experiences that buffer the impact of risk factors. Steinglass and colleagues (1987) found that when families preserved family rituals (e.g., eating dinner together) the rate of substance abuse decreased in their offspring. Hawkins (1997) supported

the claim that maintaining “healthy” family routines and rituals in alcoholic families mediated the development of alcohol problems in adult children of alcoholics. Hawkins’ study also found that maintaining healthy family routines played a mediating role in development of negative personality traits (i.e. depression and internalized shame) and drinking restraint in adult children of alcoholic parents.

As a preventative measure, health care professionals can advise at-risk families to focus on the protective factors and encourage them to provide an environment that promotes resiliency.

Slide 13: Shifting the Balance

Protective factors play a role in the development of resiliency and are used to balance the scales towards resiliency and away from vulnerability. Because risk and protective factors are not the opposite of each other, it must be remembered that increasing protective factors does not attenuate risk.



Slide 14: Prevention Messages

Genetic data and studies of environmental risks validate the wisdom of offering prevention messages to children with a positive family history of alcoholism. Health care professionals need to inform offspring that they are vulnerable for a serious disorder that can be avoided by abstinence or limiting alcohol intake to recommended low risk levels. Children suffering from the effects of parental substance use benefit by discussing their problem or by a referral for additional help. Because of lack of understanding, shame or rules of silence, family members may not seek out assistance from health care providers or discuss the problem openly.

Research has found that family members want their physician to ask about family alcohol problems and believe that physicians can be helpful to them and the alcoholic (Graham, et al., 1994). The attentive clinician may be able to initiate a series of events that eventually leads the individual with a substance use problem to sobriety and recovery, and a repair of the family dysfunction that resulted from the alcohol or drug problem. Brief interventions and

anticipatory guidance (giving healthy prevention messages) also have the potential to buffer the negative effects of life in a home affected by alcohol or drug use and improve outcomes.

RISKS AND CONSEQUENCES RELATED TO PARENTAL ALCOHOL USE DISORDERS

Slide 15: Alcohol Prenatal Risks

Regardless of the preventive interventions of health care professionals and the presence of protective factors, children with a positive family history of substance use disorders are at high risk for the development of a variety of consequences. Children whose mothers drink encounter their first health problem prior to birth. Health care professionals are well aware that prenatal exposure to alcohol can lead to fetal alcohol syndrome, alcohol related neurodevelopment disorder, and alcohol related birth defects. However, a recent study showed that children exposed prenatally to alcohol, even if they do not meet the criteria for the previously listed problems, have psychosocial, cognitive and behavioral problems that can affect them throughout their life span (Roebuck, et al., 1999).

Slide 16: Alcohol Genetic Risk: *Children of Alcoholics are 4 to 9 times more likely to develop an alcohol use disorder*

Over the last several decades, evidence from family, twin and adoption studies have supported the contribution of genetics to the familial aggregation of alcoholism. Children of alcoholics are 4 to 9 times more likely to develop an alcohol disorder than a child who had a negative parental history for alcoholism (Cotton, 1979; Goodwin, 1973; Cloninger, 1981; Bohman, 1981; Nurenberger 2004).

Study	Sample	Ratio
Goodwin, et al., 1973	Copenhagen: 5,483 non-family cases, 1924-47	3.6: 1
Cloninger, et al., 1981	Sweden: 862 males adopted by non-relatives (Type I)*	4.4: 1
Cloninger, et al., 1981	Sweden: 862 males adopted by non-relatives (Type II)**	9.4: 1
Bohman, et al., 1981	Sweden: 913 women adopted by non-relatives	3.5: 1
Nurnberger, et al 2004	United States: 8296 first-degree relatives of alcoholic probands.	6.0: 1

* *Type I: (milieu-limited) Mild parental alcoholism, mild parental criminality*

***Type II(male-limited) Early onset severe alcoholism and serious criminality*

Slide 17: Alcohol Genetic Risk (continued)

Having an identical twin with alcoholism increases an individual’s risk for the disease even more than having another family member with this disorder (Kaij, 1960; Hrubec & Omenn, 1981). The adoption of a child of an alcoholic into a family without alcoholism does not eliminate the genetic risk for acquiring the disease (Goodwin, et al., 1973). Many alcoholics from early in their drinking life have noted tolerance, or the ability to drink large amounts of

alcohol with limited effect (Schuckit, 1999). Children of alcoholics, when compared to controls, also have a low intensity of reaction to alcohol (Schuckit, 1999). Research found that 20-year-olds, with a low level of response to alcohol, had a higher rate of alcoholism by age 35. The low intensity of reaction to alcohol in children of alcoholics may help explain the relationship between family history and alcohol problems (Schuckit, 1998).

Slide 18: Environmental Risk

Wand and colleagues (1998) found that opioid activity is significantly lower in alcohol dependent individuals and their offspring. Altered brain activity may make them more vulnerable to addiction. However, these findings are complicated by environmental factors, such as stress. Chronic stress can alter opioid activity. Living in alcoholic families has been found to be stressful for family members (Jackson, 1954). Problems in the family environment of children of alcoholics include increased conflict, violence, disorganization and isolation. Family stress, related to growing up in chaotic alcoholic families, may act in an additive fashion with genetic risk increasing children's vulnerability to addiction and other medical and social problems. Role modeling of alcohol and drug use and permissive parental attitudes towards children's use are also related to the increased risk of use by children (Hawkins, et al., 1992).

Slide 19: Consequences for Children of Alcoholics

Adolescents with an alcoholic parent are three times more likely to develop a psychiatric syndrome than adolescents without an alcoholic parent (Lynskey, et al., 1994). Children of alcoholics are hospitalized more often, incur greater medical charges and have more illness, such as psychiatric problems, poisoning, injuries and substance abuse (Woodside, et al., 1993).

Slide 20: Consequences for Children of Alcoholics (continued)

Children of alcoholics have higher absentee rates from school, are less neatly groomed and receive less help with homework (Kumpfer, 1993). Although they have more health, social and adjustment problems, these problems are often subclinical (Bennett, et al., 1987) and children may not be referred for mental health care or to prevention, focused support programs (Alateen or school based student assistance programs).

LIFE CYCLE CONSEQUENCES RELATED TO ALCOHOLISM

Slides 21-22: In Nuclear Families with an Alcoholic Father

Leonard, et al.(2000) recently summarized several papers that were presented at the 1999 RSA meeting in Santa Barbara that examined developmental issues in alcoholic families. Eiden and Leonard presented on the impact of a father's alcoholism on parenting and infant development. They reported: 1) high levels of antisocial behavior and depression in both parents; 2) increased aggression between partners, 3) high aggravation and less sensitivity towards infants, lower positive engagement and verbalization with infants and infants reported as being difficult by fathers; 4) mothers with alcoholic partners and fewer verbal interactions with their infants; 5) overall parenting patterns displayed infant avoidance. Then authors concluded that a father's alcoholism appears to impact family functioning and

parenting during their children's infancy and may place children at high risk for maladaptive development throughout their lifetime.

Slide 23: During Young Adulthood

A report by Leonard et al. (2000) examined the difficulties young adults who are children of alcoholic parents have leaving home. They found that these young adults left home earlier, experienced more conflicts with their parents during the process, had more negative feelings about the transition and were more likely to return home after their first attempt to leave than their peers who did not have an alcoholic parent. The greater likelihood of their own alcohol use during adolescence and the cumulative effects of parental alcoholism may contribute to increased difficulty during this normative developmental phase of life.

A third report by Leonard and Mudar explored drinking in couples married for two years. They note that marriage is an important transition generally, but also in terms of establishing drinking patterns. They found that individuals with strong family histories of drinking were more influenced by their husband's or wife's drinking than partners from families without this history. Their results suggest that family drinking patterns continue into the establishment of new marital relationships.

Schuckit (1994) found that daughters of alcoholics are more than twice as likely to marry an alcoholic as women who do not have an alcoholic father. Olmsted et al (2003) found that male adult children of alcoholics had a greater likelihood of becoming alcoholic than female adult children of alcoholics; and both men and women of alcoholic parents were more likely to marry an alcoholic than adult children of non-alcoholic parents. Growing up in the presence of alcoholism seems to condition women to live a second time in a familiar family environment.

A family developmental perspective suggests that at each phase of the family life cycle, the impact of addiction can influence transitions and children can be affected in ways that can last a lifetime. Health care professionals should be alert to the possibility of additional stress during transition periods in the lives of patients that have a family history of alcoholism.

Slide 24: Adult Relationships

Watt (2002) found that adult children of alcoholics had significantly different marital status and cohabiting patterns compared to adults without alcoholic parents. Adult children of alcoholic parents were more likely to have never been married, more likely to be unmarried but cohabitating with a partner, and/or more likely to be divorced. Adult children of alcoholic parents that were married were found to be less happy, more independent seeking and more disengaged in their marriages. Adult children of alcoholic parents were also more likely to marry a substance abuser. These patterns were observed in both men and women.

Slide 25, Adult Children of Alcoholics

Griffin (2005) studied the long-term impact of parental alcoholism on women and found that women with alcoholic parents scored significantly worse on scales of social adjustment, depressed mood and life satisfaction and were significantly more likely to report alcohol

problems in adulthood, when compared to women without alcoholic parents. Watt (2002) found adult men with alcoholic parents reported lower levels of educational attainment and both men and women with alcoholic parents reported lower levels of self-esteem compared to adults without alcoholic parents.

Slide 26, Nicotine Dependence

Cuijpers and Smit (2002) explored the relationship between parental alcoholism and nicotine use and dependence in adult children. Among regular users of nicotine ACOAs had a higher rate of nicotine dependence than non-COAs even when controlling for anxiety and affective disorders. ACOAs started regular tobacco use about a year and a half earlier than non-COAs.

IMPACT ON FAMILIES FROM DRUG USE

Slide 27: Genetic Transmission of Drug Disorders

Studies regarding the family influence on the development of problems with drugs other than alcohol are beginning to appear in the literature. The genetic risk for alcoholism does not appear to be the same as the genetic disposition for problems with other drugs (Bierut, et al., 1998). Prescott and Kendler (1998) have shown that genetics contribute significantly to the progression from use of cocaine or marijuana to abuse or dependence. In twin studies, genetic factors account for approximately 60 to 80% of the differences in abuse and dependence rates for marijuana and cocaine between fraternal and identical twins. Additional studies have found that genetic factors are stronger in males than in females (van den Bree, et al., 1998) that different drugs have different vulnerabilities and that heroin has a greater genetic influence than other drugs (Tsuang, et al., 1998).

Slide 28: Children of Drug Dependent Parents

Johnson and Leff (1999) suggest that the children of drug-addicted parents are at greater risk for later dysfunctional behaviors and deserve significant attention to prevent intergenerational transmission of drug problems. A study by Hawkins et al. (1992), suggests that family modeling of drug using behavior and permissive parental attitudes toward children's drug use are increased risk factors for alcohol and other drug abuse by children in these families. Children of narcotic addicts exhibit a pattern of early deviant behavior, including hostility, association with deviant peers and a negative perception of the home atmosphere that may lead to later drug addiction (Nurco, et al., 1999).

Slide 29: Chronically Stressed Families

The amount of evidence-based data regarding families with members, who have substance use disorders, has grown considerably over the last decade. However, clinically generated information has always contributed to the care and understanding of these families and more recently, has filtered into popular literature related to the topic. Dysfunctional families, co-dependent, enabling behaviors, and family roles have become familiar terms. As discussed earlier in this module, families of individuals with substance use disorders often experience stress that can affect them physically and psychologically. Living with chronic stress can result in families interacting in unhelpful ways. Stigma, shame, and guilt alter coping mechanisms and result in behaviors that enable the chemically dependent member to continue drinking or using drugs. Family members protect themselves from additional psychological pain by the use of defense mechanisms. Various authors (Black, 1982; Wegscheider, 1989)

have described stereotypic roles that can arise in chemically dependent families and families, in general. These roles include, but are not limited to, the chief enabler, the caretaker, the family hero, the fixer, the adjuster, the placater, the scapegoat, the lost child and the clown. Even though these are popular concepts, there is no scientific basis for them. It is important, however, for health professionals to remember that people learn to survive in a variety of ways when they are living in chronically stressed and chaotic family environments.

Slide 30: Racial and Ethnic Differences

A paucity of studies have examined the characteristics and life experience of children from alcoholic families who are African American, Hispanic, Asian, or members of other American minority populations. Rarer still is research comparing African American and white adults with alcoholic parents in the same study. Brisbane and Stuart (1985) concluded that black women of alcoholic parents experienced many of the same types of problems as those reported in studies of whites. In an exploratory study of 40 black alcoholic women with alcoholic parents, Brisbane (1986-87) found that subjects with an alcoholic mother were more critical of their parents' alcoholism than subjects with alcoholic fathers. An alcoholic father stirred neither positive nor negative emotions compared to the depth of feeling reserved for alcoholic mothers. A study of 100 randomly selected black undergraduate students found that, similar to white students, those with alcoholic parents were heterogeneous with no deficits in mastery of developmental tasks (specifically, autonomy, mature relationships, and purpose) when compared to offspring of nonalcoholic parents (Rodney, 1995). Since no white subjects were included in these studies, it is unclear to what extent these findings are unique to blacks.

In an effort to address the absence of information about the psychological adjustment of Hispanic adults with alcoholic parents, Harman and Arbona (1991) conducted an exploratory study of the types and degree of psychological distress reported by Hispanic college students with alcoholic parents. When compared with children of non-alcoholic parents, children of alcoholic parents reported more somatic complaints and physical conditions linked to psychological factors or conflicts. No difference was found in reported use of alcohol and other drugs. Women reported higher levels of anxiety, depression, and neuroticism than men did. Again, since no white subjects were included, it is unclear to what extent ethnic differences exist. Werner (1989) studied Asian and Polynesian children in Hawaii but did not note racial or ethnic differences in her findings.

In a rare study comparing racial minority subjects to whites, Ackerman and Gondolf (1991) administered an index measuring symptoms attributed to adults from alcoholic homes. Contrary to the authors' hypothesis, minorities had significantly fewer adjustment problems than whites. However, since studies of offspring of alcoholic parents that compare minority groups and whites are limited, it is not possible to know whether models developed in majority populations are applicable to minority groups. Nor do the few studies on minority subjects address the applicability of findings to white or other minority populations.

Slide 31: Cultural Competence

Although there is a paucity of research, health care professionals must be sensitive to cultural differences in their patients. (See Module I for more information on Cultural Competence.)

Slide 32: Consequences for Family Members

Members of families of alcoholics have more visits to their primary care physician for stress related conditions and receive more psychotropic medications (Frank, et al., 1992).

Slide 33: Clinical Presentations of Children of Alcoholics

Children may exhibit the stress through physical problems (Baird, 1992) such as:

- Sleep problems
- Gastrointestinal problems, including vague epigastric pain, stomach aches and nausea
- Headaches
- Musculoskeletal pain
- Enuresis
- Vague symptoms such as weakness, dizziness, fatigue or lack of appetite
- Accidents, injuries and poisonings
- Most often present NO symptoms

The absence of symptoms does not imply that the child has no emotional or physical problems. Because many children live with alcoholic or other substance-abusing parents, but may not exhibit symptoms, health care professionals should routinely ask if there are concerns about alcohol or other drug use by any members in the family.

Slide 34: The Majority of Children of Alcoholics are not identified and assisted

There are many reasons why many of these children are not detected. These include: lack of noticeable symptoms, the health professional's hesitancy to ask questions or lack of knowledge about how to do so and what to ask, the stigma attached to substance abuse and dependence, the patient's feelings of fear or guilt.

Slide 35: Reluctance to Ask About Family Problems

Health care professionals may be reluctant to ask children, especially pre-teens, about family substance use problems. Some may fear it places a child in an untenable position of betraying a family secret or, worse, increases a child's risk for maltreatment. There is a rich clinical literature written about the conspiracy of silence that characterizes many of these families and the reluctance of health professionals to ask about substance abuse. Limited research has addressed this issue. One study found that when children were asked about family SUD's, parents expressed no negative reaction (Duggan, et al 1991). Another found that patients wanted their physicians to ask about family alcohol problems (Graham, 1994). Presently, no literature supports the position that asking about concerns regarding alcohol or other drug use by family members puts children at risk. Randomized clinical trials cannot be conducted to test whether asking children about family SUD's will harm or help them. Without evidenced-based support, clinical and expert judgment must be relied upon.

ROLE OF THE HEALTH CARE PROFESSIONAL

Slide 36: Helping Children and Adolescents

With funding from the Center for Substance Abuse Prevention, the American Academy of Addiction Psychiatrists and the National Association for Children of Alcoholics convened an expert panel to address the issue of how health care professionals can screen for parental SUD's. The panel developed the document, "Helping Children and Adolescents in Families Affected by Substance Use: A Guide for Health Care Professionals" (Adger, et al., 2000). This document assists health care professionals in asking children and adolescents about family alcohol and drug use. The issue of family alcohol use can be directed to parents or to younger children in the presence of parents. Older children can be asked while being examined alone. Any delicate information that a family member confides to a health professional must be treated with care. One would not confront parents with information that a child had shared about a family SUD, but would engage the parent in dialog regarding the issue. Doing so provides an opportunity to assess the parent's readiness to change and to engage in making a plan. If the health care provider is uncomfortable in establishing a dialog with the parent, at the very least, the professional can validate the child's concern.

Slide 37: Core Competencies for Health Care Professionals

To address the issue of parental problems with alcohol and other drugs, health care professionals need training (Werner, et al., 1999). With sufficient knowledge, health care professionals can play a powerful role in strengthening family resiliency and in offering support, guidance and referrals. To guide health care professional in learning about family SUD's, The National Association of Children of Alcoholics (NACoA) directed the development of Core Competencies for Involvement of Health Care Providers in the Care of Children and Adolescents in Families Affected by Substance Abuse (Adger et al., 1999) (See Appendix I for entire text of Core Competencies). The Core Competencies suggest that all health care providers should be prepared to provide care at Level I. Some health care professionals, involved with the care of children, will have specialty training so that they will be functioning at Level II or III. The desired outcome of the HRSA/AMERSA/SAMHSA/CSAP fellowship is to insure that all faculty fellows are capable of preparing their students at Level I competency.

Slides 38-39: Core Competencies for Involvement of Health Care Providers in the Care of Children and Adolescents in Families Affected by Substance Abuse

These slides contain Level I of the core competencies (See Appendix I for entire text of Core Competencies).

Level I

For all health professionals with clinical responsibility for the care of children and adolescents:

1. Be aware of the medical, psychiatric and behavioral syndromes and symptoms with which children and adolescents in families with substance abuse present.
2. Be aware of the potential benefit to both the child and the family of timely and early intervention.
3. Be familiar with community resources available for children and adolescents in families with substance abuse.

4. As part of the general health assessment of children and adolescents, health professionals need to include appropriate screening for family history/current use of alcohol and other drugs.
5. Based on screening results, determine family resource needs and services currently being provided, so that an appropriate level of care and follow-up can be recommended.
6. Be able to communicate an appropriate level of concern, and offer information, support and follow-up.

Slide 40: Health Care Practitioners Need to Ask About and Screen for Substance Use in the Family

“Helping Children and Adolescents in Families Affected by Substance Use: A Guide for Health Care Professionals” (Adger, et al., 2000), which is described in Slide #33, summarizes information about substance use disorders, the impact on children, the need for intervention and the present lack of inquiry by health care professionals. It also includes tools to help the busy health care practitioner ask questions and intervene with patients and families. It emphasizes that not looking for signs and symptoms of family alcohol and other drug use compounds the problem and reinforces the hopelessness or despair of those who live with it. It is well accepted in most primary care disciplines that questions about alcohol and drugs should routinely be asked beginning at the pre-natal visit and throughout the span of child and adolescent care. The problem is that it currently does not happen.

Slide 41: Expected Outcomes

Clinicians who do not screen for family SUD’s, ignore the obvious signs of distress in a child or adolescent that come from living with an alcoholic or drug addict, and take no action to comfort the child or adolescent, often compound the problem. Inaction serves to reinforce the despair and hopelessness commonly found among those who live with substance use disorders. The guide developed by NACoA’s expert panel (Adger, et al., 2000), offers suggestions for the positive outcomes outlined below.

1. The children or adolescents will understand that there are lots of children in similar families—that they are not alone. Many children of parents with substance use problems believe that their situation is unique and this adds to their feelings of isolation and shame. When the clinician validates and normalizes the children and adolescents’ perception that “something is wrong” at home, it helps them to understand that they are not the only ones who have to deal with this difficulty.
2. The children or adolescents will understand that they did not cause the drinking or drug use or the consequent behaviors—it is not their fault. They need to discover that they did not cause the substance use problem or disorder, that they cannot cure it, but that they can care for themselves in order to lead a healthier, happier life. Children and other non-dependent members of the family need to understand that alcohol or drug dependence is a disease and that it can affect all members of the family.
3. The children or adolescents will come to understand that their concern is valid—that there is a problem. Individuals who live in a household with somebody who has a substance use problem often have strong emotional reactions and dysfunctional

behaviors that result in problems with friends, poor performance in school, and sometimes, trouble with the law. If they understand that these problems are a common reaction to the home situation, they can then take the first step towards change.

4. The children or adolescents will know where to turn for help. Many family members who live with alcohol or drug use problems have no idea where to go for help. The clinician can remedy this situation by providing addresses, telephone numbers, websites, and contact people. Adults can be referred to Al-Anon and children and adolescents to Alateen, school counselors or school-based student assistance programs.

Slide 42: Despite feeling a responsibility to inquire about AOD in patients and families there appears to be a cultural ambivalence and a lack of skills in doing so.

However, with sufficient knowledge/training, health care professionals can play a significant role by asking the important questions.

Slide 43: Clinical Algorithm

The authors of the guide developed by NACoA's expert panel (Adger, et al., 2000) suggest that the most important question that health professionals should, but most likely Never ask is: "Have you ever been concerned about the drinking or drug use of someone in your family?" This algorithm was developed for health care professionals, especially pediatricians, family physicians, nurse practitioners and physician assistants. However, the basic principles in the algorithm are applicable to other professionals who care for children. The approach can be modified for various settings and to fit the context in which each professional works with children. (See Appendix II for the complete Clinical Algorithm including Examples for the Role of the Health Care Professional.) The following slides (39-46) highlight parts of this suggested algorithm that can be used in talking to patients.

Slide 44: The Most Important Question you NEVER asked

The Question: "Have you ever been concerned about the drinking or drug use of someone in your family?"

Slide 45: To Whom and When Should the Question be Asked?

To whom? Parent(s) and/or children either alone or together. If child is brought to visit by a grandparent, nanny, or anyone else, the question is still appropriate.

When? At all health maintenance visits including any initial or pre-natal visit. At times when the differential diagnosis includes the possibility of a substance-related illness or injury.

How? May be a part of a written questionnaire and/or a verbal history taken by health care practitioner or staff member.

Why? To set the groundwork for possible later discussion. To let families and children know that the practitioner believes that this is a health issue and is able and willing to be of assistance. To identify families with problems and

begin the process of intervention. To help broach a question that may be hard to ask.

Slide 46: If the Answer Is NO

1. *No further action at this time.* Repeat the question in one year or if circumstances suggest earlier intervention.

2. *Prevention Message:* “I ask because many of my patients are concerned about someone in their family, but are uncomfortable about discussing it. Please let me know if you ever have these concerns.”

Slides 47: If the Answer Is UNCERTAIN

Especially if body language suggesting discomfort with the question such as a furtive look to a parent or hesitation occurs. Consider these responses:

1. Consider an initial question such as, “Can you tell me more about that?” or “Do you understand what I’m asking?”

Slide 48: If the Answer Is UNCERTAIN (continued)

2. “Many of my patients are concerned about someone in their family or even a close friend who is drinking or using drugs, but are afraid to talk about it. Perhaps you’d like us to discuss this more at some other time.”

Slide 49: If the Answer Is UNCERTAIN (continued)

3. “Well if you are ever concerned, will you please let me know?”
(Make a notation in the chart to ask the question at a later visit).

Slides 50-51: If the Answer Is YES

The clinician should be actively listening for whether the family substance abuse is associated with:

1. A persistent or ongoing illness, injury or health concern

a. Initial Response: “Tell me more about it.”

b. Concluding Statements: “Drinking or drug use by a family member can be harmful to a child’s health. Let me give you some information...” and/or “Maybe we should continue to discuss this” and/or “I would be happy to refer you to someone who is knowledgeable about alcohol and drug use.”

Offer a pamphlet about alcohol and drug abuse, its impact on children, and about intervention and treatment options. Make a note on the chart to raise the issue again at the next meeting.

Slide 52: If the Answer Is YES (continued)

2. Child Abuse or Neglect

Ask yourself, ‘Is there a potential for abuse or neglect?’ If you suspect child abuse or neglect, consider a referral to child protective services.

3. Child's Own Substance Use

Determine the nature (Details of screening will be discussed later in this module)

Slide 53: Helping Patients and Families Change

To help busy health care practitioners interview children, a modified version of a motivational interviewing technique was designed with the acronym, **TEAR** (teach, express empathy, advise action and reach agreement). Motivational Interviewing is a set of techniques that promote behavior change using an empathic, respectful, patient-centered manner. A growing body of research demonstrates the efficacy of motivational interviewing as a useful strategy in helping patients acquire healthy behaviors. The active ingredients in promoting change have been summarized in the acronym FRAMES (See Appendix III.) The NACoA Guide (Adger et al., 2000) suggests that the clinician use an abbreviated form of FRAMES called **TEAR** because this is easier to use in a brief intervention with children or adolescents in a busy clinical office. Following is an example of how a health care practitioner would use the abbreviated motivational interviewing techniques called **TEAR** to help a young teenager who has begun to get into fights in school and whose father has an alcohol problem.

T **TEACH**

“Billy, it is okay to be concerned about a parent or another person’s alcohol or drug use. One of the most important initial things we can do is help you to learn more about how alcohol and drug use affect the individual involved such as your Dad, as well as how it affects your and others who live in the same house and care about him.”

E **EXPRESS EMPATHY**

“Billy, I’m concerned about what we just talked about and how it is making you feel. I’d like to help you so that you can feel better and resume getting the good grades that you used to get in school.”

A **ADVISE ACTION**

“Billy, I think it would be helpful for you to learn about alcohol and drug use and how it can affect everyone in the family. This will also help you learn other ways to deal with your frustration and anger. What are you willing to do?”

R **REACH AGREEMENT**

“Billy, I’m glad you are willing to agree to talk with your school counselor in order to learn more about alcohol and drug use and to explore attending an Alateen meeting. I think this is great and I know you can be successful if you try this.”

Slide 54: Change is Difficult

Health care practitioners must remember change is difficult, change takes time and ambivalence is normal. They should not expect immediate results. In order for patients to

make changes, they must move from a state of not being ready to change, into a period of being unsure about change, and finally into a mode of readiness for change. When health care practitioners use motivational interviewing, it provides them with a strategy that is effective, increases patient satisfaction and decreases professional frustration.

Health care professionals can make a difference in the lives of children and adolescents living in families with substance abuse disorders if they take the time to ask the right questions, provide information/education, offer support and guidance, and suggest referrals to community and school resources.

WORKING WITH ADOLESCENTS

Slides 55-56: Adolescent Substance Use

Thus far, this curricular module has dealt with the consequences experienced by children with family substance use disorders. However, it is also important for health care professionals to explore the possibility of adolescent substance use because of the increased risk of substance use disorders in children from alcoholic families. Although alcohol is the most commonly used substance by adolescents, those with substance use disorders are rarely ever involved exclusively with alcohol. Most adolescents start with alcohol and then begin to see weekend binge drinking as diminished in danger. In 2003, 36 % of ninth graders and 56% of twelfth graders reported drinking at least one alcoholic beverage in the past 30 days. Also, twenty percent of the ninth graders and 37% of the twelfth graders reported drinking 5 or more drinks at one occasion (Grunbaum, 2004).

An early starting age of alcohol use can be a risk for alcoholism. The relationship between early drinking and alcohol dependence is associated with a genetic risk of alcohol problems, especially in women. Simply delaying the age of initiation of alcohol use in genetically vulnerable children may not be as useful as strategies to prevent the progression from early drinking to heavy use (Prescott & Kendler, 1999).

Langenbucher and colleagues (2000) found that adolescents do not drink as often as adults (13.8 vs. 21.0 day per month), but they consumed as much alcohol per occasion as adults. Adolescents who develop problems usually proceed from alcohol to cannabis and on to other illicit substances.

Deas et al. report that dependent adolescents have substantial rates of mood and comorbid conduct disorders. As with adults, female adolescents with alcohol problems outnumber males in the rates of comorbid depression. However, the prevalence rate of conduct disorders is equal in male and female adolescent alcoholics (Deas, et al., 2000). Expectancy, the mental process that links the use of alcohol with pleasure or disgust, changes as children grow into adolescents.

Dunn and Goldman (1998) found a modification from the negative effects of alcohol use to perceived social benefits of drinking as children got older. If children expect positive effects from drinking, they are more likely to initiate drinking earlier and to drink more heavily.

Challenging the positive expectations has been shown to decrease the amount of consumption (Darkes & Goldman, 1998).

Slide 57: Assessing Adolescent Patients

A clinical assessment of an adolescent patient should include: 1) personal factors (signs of a conduct or mood disorders, risk taking, aggressive or hostile behaviors); 2) family factors (history of addiction, family attitude towards alcohol and drug use, neglect and abuse).

Slide 58: Assessing Adolescent Patients (continued)

In addition, the assessment of an adolescent patient should include: 3) peer involvement (amount of alcohol or types of drugs they use ;) 4) school factors (low achievement or learning problems) and the adolescent's history of use (age at initiation, pattern, type and amount and signs of dependency).

Slide 59: CRAFFT

An excellent example of an adolescent screening questionnaire is the CRAFFT (Knight, et al., 1999), which includes the following questions:

C	Have you ever ridden in a <u>CAR</u> driven by someone (including yourself) who was high or had been using alcohol or drugs?
R	Do you ever use alcohol or drugs to <u>RELAX</u> , feel better about yourself?
A	Do you ever use alcohol or drugs while you are by yourself (<u>ALONE</u>)?
F	Do you ever <u>FORGET</u> things you did while using alcohol or drugs?
F	Do your <u>FAMILY</u> or <u>FRIENDS</u> ever tell you that you should <u>CUT</u> down on your drinking or drug use?
T	Have you ever gotten into <u>TROUBLE</u> while you were using alcohol or drugs?
Score	2 or more yes answers indicate a problem for follow-up.

As with other patients, it is important to establish a comfortable rapport with adolescents and to start the interview with open-ended questions. However, because adolescence covers many years, it is important to ask questions in an age specific manner. The issues of privacy and confidentiality must be addressed. Practitioners often have their own styles about interviewing adolescents without parents present, especially when obtaining sensitive information. The ground rules regarding confidentiality should be discussed prior to obtaining information. If a practitioner promises every thing the teen shares will be held in strictest confidence, a dilemma is created if the teen reveals information, such as suicidal thoughts. It is preferable to be honest up front. The health care provider should explain the limits of confidentiality and reassure the teen no information will be shared without the practitioner making a plan with the teen for when and how the information will be passed on. For example, a health care professional can say, "If you tell me something that makes me believe that you are not safe, I will need to share this information with someone. Before I do this, I will talk with you about how we should proceed and who I should inform."

RESOURCES

Slides 60-61: National Resources Useful to Individuals

Referral sources for children and families affected by substance abuse vary by communities. Al-Anon, Alateen and school-based student assistance programs are often available. Family members can also be referred to a “family intervention specialist” or a mental health professional that has knowledge about the impact of substance use disorders on families. (See Appendix IV for Resources for Children and Families.)

Each U.S. State has an agency or department responsible for the alcohol/drug-related programs, resources, and initiatives offered throughout the State. States vary widely in the titles of these agencies and in their organizational affiliation within state government structures. In some instances, the addiction agencies are combined with mental health services. Many states also have resource centers with helpful free materials.

Alcoholics Anonymous (AA) is a voluntary fellowship open to anyone who wants to achieve and maintain sobriety and is an important adjunct to many treatment programs. Two individuals founded the fellowship in 1935 in an effort to help others who suffer from the disease of alcoholism. AA is the oldest of the organizations designed to help alcoholics help themselves. It is estimated that there are more than 2 million members in local AA groups worldwide.

Al-Anon is an organization for spouses and other relatives and friends of alcoholics. The Al-Anon groups help families cope with the problems that result from another's drinking or drug use, and they help foster understanding of the alcoholic through sharing experiences. Local groups are listed in your telephone directory under “Al-Anon Family Groups.”

Alateen, a part of Al-Anon, is for young people whose lives have been affected by the alcoholism of a family member or close friend. Members of Alateen fellowships help each other by sharing their experiences, hopes, and strength. Alateen is listed in some telephone directories, or information may be obtained by contacting local Al-Anon groups.

Narcotics Anonymous (NA) is an international, community-based association of recovering drug addicts. Started in 1947, it sprang from the Alcoholics Anonymous movement. The NA movement is one of the oldest and largest of its type, with nearly twenty thousand weekly meetings in seventy countries.

The National Association for Children of Alcoholics (NACoA) is a membership organization and a clearinghouse for information and support materials for children of alcoholics and for those in a position to assist them. NACoA has videos, booklets, and newsletters and a kit for primary health care providers.

Children of Alcoholics Foundation serves the children of alcoholics and other substance abusers. The foundation developed *Pandora's Box*, an educational tool to assist health care professionals in dealing with sensitive issues especially family alcoholism, child abuse and sexual abuse.

The National Council on Alcoholism and Drug Dependence (NCADD) is a nonprofit national voluntary health agency with several hundred local affiliates that are well acquainted with the problems of alcoholics and drug addicts and are dedicated to helping them. Information about addiction treatment opportunities is available through the local affiliates. In some instances, counseling of alcoholics and their families may be provided through the local unit, as well as support groups and other preventive interventions for children of substance abusers. Look for the listing of your local NCADD affiliate in the telephone directory.

The National Association of Student Assistance Professionals (NASAP) is a non-profit organization, founded in 1987 by professionals who were concerned about the problems of student substance abuse, violence and academic under achievement. NASAP represents the interests of student assistance professionals across the U.S.

The National Clearinghouse for Alcohol and Drug Information is a supplier of relevant materials covering the entire gamut of alcohol- and drug-related issues. Its website has an extensive section for young people. Many materials are free and available to be ordered through an 800 number or over the Internet.

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) supports and conducts biomedical and behavioral research on the causes, consequences, treatment, and prevention of alcoholism and alcohol-related problems. NIAAA also provides leadership in the national effort to reduce the severe and often fatal consequences of these problems. *Alcohol Alert* is a free quarterly bulletin, which disseminates important research findings alcohol.

The National Institute on Drug Abuse (NIDA) has a mission of bringing the power of science to bear on drug abuse and addiction. NIDA supports and conducts research and ensures the effective dissemination and use of the results of research to significantly improve drug abuse and addiction prevention, treatment, and policy. *NIDA Notes*, the Institute's free bimonthly newsletter, covers research information.

CONCLUSIONS/SUMMARY

Slide 62: We Must Be Child Health Advocates

Health care professionals can make a powerful difference in the lives of children and adolescents living in families with substance abuse disorders if they take the time to ask the right questions, provide information/education, offer support and guidance, and suggest referrals to community and school resources.

Slide 63-64: Summary

- While the majority of children of alcoholics will grow up to lead healthy and productive lives, many will not
- The challenge before us is to identify them early and intervene in a timely and meaningful manner

- According to the National Association for Children of Alcoholics about 43% of the adult population in the United States has experienced family alcoholism and almost 1 in five adult Americans (18%) lived with an alcoholic at some point while growing up.

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Appendices

- I. Core Competencies For the Involvement of Health Care Providers in the Care of Children and Adolescents in Families Affected by Substance Abuse**
- II. Algorithm: The most important question you NEVER asked**
- III. Helping Patients and Families Change**
- IV. Resources for Children and Families**
- V. Case Studies**

Appendix I

Core Competencies for Involvement of health Care Providers in the Care of Children and Adolescents in Families Affected by Substance Abuse

These competencies are presented as a specific guide to the core knowledge, attitudes and skills that are essential to meeting the needs of children and youth affected by substance abuse in families.

There are over 28 million children of alcoholics in America; almost 11 million are under the age of eighteen. Countless other children are affected by substance-abusing parents, siblings or other caregivers. There is an association between child physical, emotional and sexual abuse and neglect, domestic violence and substance abuse in the family. All children have a right to be emotionally and physically safe. No child of an alcoholic or other substance-abusing parent should have to grow up in isolation and without support. Recognizing that no one is unaffected in families with substance abuse, health professionals should play a vital role in helping to optimize the health, well being and development of children and adolescents from these families and should recognize, as early as possible, associated health problems or concerns.

It is the hope of the **National Association for Children of Alcoholics (NACoA)** that organizations representing health care professionals will adopt these competencies or competencies modeled from them. Developed by a multi-disciplinary professional advisory group to NACoA, these competencies set forth three levels for professional involvement with children who grow up in homes where alcohol and other drugs are a problem. All health care providers should aspire to Level I. Resources and programs should be made available for the training of professionals who desire to achieve competency at Levels II and III.

Level I

For all health professionals with clinical responsibility for the care of children and adolescents:

1. Be aware of the medical, psychiatric and behavioral syndromes and symptoms with which children and adolescents in families with substance abuse present.
2. Be aware of the potential benefit to both the child and the family of timely and early intervention.
3. Be familiar with community resources available for children and adolescents in families with substance abuse.
4. As part of the general health assessment of children and adolescents, health professionals need to include appropriate screening for family history/current use of alcohol and other drugs.
5. Based on screening results, determine family resource needs and services currently being provided, so that an appropriate level of care and follow-up can be recommended.

6. Be able to communicate an appropriate level of concern, and offer information, support and follow-up.

Level II

In addition to Level I competencies, health care providers accepting responsibility for prevention, assessment, intervention and coordination of care of children and adolescents in families with substance abuse should:

1. Apprise the child/family of the nature of alcohol and other drug abuse/dependence and its impact on all family members and strategies for achieving optimal health and recovery.
2. Recognize and treat, or refer, all associated health problems.
3. Evaluate resources — physical health, economic, interpersonal and social — to the degree necessary to formulate an initial management plan.
4. Determine the need for involving family members and significant other persons in the initial management plan.
5. Develop a long-term management plan in consideration of the above standards and with the child or adolescent's participation.

Level III

In addition to Levels I and II competencies, the health care provider with additional training, who accepts responsibility for long-term treatment of children and adolescents in families with substance abuse should:

1. Acquire knowledge, by training and/or experience, in the medical and behavioral treatment of children in families affected by substance abuse.
2. Continually monitor the child/adolescent's health needs.
3. Be knowledgeable about the proper use of consultations.
4. Throughout the course of health care treatment, continually monitor and treat, or refer to care, any psychiatric or behavioral disturbances.
5. Be available to the child or adolescent and the family, as needed, for ongoing care and support.

(Source: Adger H, Macdonald DI, Wenger S. Core competencies for involvement of health care providers in the care of children and adolescents in families affected by substance abuse. *Pediatrics*. 1999;103(5):1083-1084.)

Appendix II

CLINICAL ALGORITHM the most important question you NEVER asked

The Question: “Have you ever been concerned about the drinking or drug use of someone in your family?”

If the answer is NO

1. *No further action at this time.* Repeat the question in one year or if circumstances suggest earlier intervention.
2. *Prevention Message:* “I ask because many of my patients are concerned about someone in their family, but are uncomfortable about discussing it. Please let me know if you ever have these concerns.”

If the answer is UNCERTAIN

Especially if body language suggesting discomfort with the question such as a furtive look to a parent or hesitation occurs. Consider these responses:

1. Consider an initial question such as, “Can you tell me more about that?” or “Do you understand what I’m asking?”
2. “Many of my patients are concerned about someone in their family or even a close friend who is drinking or using drugs, but are afraid to talk about it. Perhaps you’d like us to discuss this more at some other time.”
3. “Well if you are ever concerned, will you please let me know?”
(**Make a notation in the chart to ask the question at a later visit**).

If the answer is YES

The clinician should be actively listening for whether the family substance abuse is associated with:

1. **A persistent or ongoing illness, injury or health concern**
 - a. Initial Response: “Tell me more about it.”
 - b. Concluding Statements: “Drinking or drug use by a family member can be harmful to a child’s health. Let me give you some information...” and/or “Maybe we should continue to discuss this” and/or “I would be happy to refer you to someone who is knowledgeable about alcohol and drug use.”Offer a pamphlet about alcohol and drug abuse, its impact on children, and about intervention and treatment options. Make a note on the chart to raise the issue again at the next meeting.
2. **Child Abuse or Domestic Violence**

Ask self, ‘Is there a potential for abuse or neglect?’ If you suspect child abuse or neglect consider a referral to child protective services.

3. Child's Own Substance Use

Determine the nature

To Whom and When should the question be asked?

- To whom?** Parent(s) and/or children either alone or together. If child is brought to visit by a grandparent, nanny, or anyone else, the question is still appropriate.
- When?** At all health maintenance visits including any initial or pre-natal visit. At times when the differential diagnosis includes the possibility of a substance-related illness or injury.
- How?** May be a part of a written questionnaire and/or a verbal history taken by health care practitioner or staff member.
- Why?** To set the groundwork for possible later discussion. To let families and children know that the practitioner believes that this is a health issue and is able and willing to be of assistance. To identify families with problems and begin the process of intervention. To help broach a question that may be hard to ask.

Examples

1. During a routine school physical with a 12-year-old girl, she says:

"My Mom and Dad drink too much."

The parents are not present.

Possible clinician responses:

- Ask her open-ended questions such as: "Tell me more about that."
- Tell her that many other children have to deal with this problem too.
- Tell her that it is not her fault.
- Ask her if she would like you to talk with her parents.
- Give her printed information, websites and phone numbers.
- Refer her to a school counselor or to Al-Ateen.
- Consider a referral to child protective services if you suspect abuse or neglect.

2. During a check-up for a stomachache with an 8-year-old boy, he says:

"Daddy drinks too much."

The mother is present.

Possible clinician responses:

- Ask open-ended questions such as: "Tell me more about that."
- Ask how his Dad's drinking worries him. (note: his current problems might be related to his dad's drinking.)
- Ask the mother if she shares her son's concerns or has concerns of her own.
- Tell him that it is not his fault.
- Ask him and his mother if they would like suggestions of where they can get help.
- Give them printed information, websites, and phone numbers.
- Consider a referral to child protective services if you suspect abuse or neglect.

(Source: Adger H, Blondell R, Cooney J, Finch J, Graham A, Macdonald DI, et al. *Helping Children And Adolescents In Families Affected By Substance Use*. Rockville, MD: Center for Substance Abuse Prevention, U. S. Substance Abuse and Mental Health Services Administration (Contract to American Academy of Addiction Psychiatry), 2000.)

Appendix III

Helping Patients and Families Change

Health care practitioners are familiar with patients who have health problems related to their behaviors — smoking, drinking, diet or exercise. Practitioners also encounter children and adolescents with unhealthy behaviors related to family members use of alcohol or drugs. Although patients can acknowledge the benefits of changing their behaviors, they may lack the knowledge or interest to change. Some patients eventually make the decision to change, but “get stuck” trying to put the new behaviors into action. They may belittle themselves or feel guilty about their inability to change.

In order for patients to make changes, they must move from a state of:

- ‡ not being ready to change,
- ‡ into a period of being unsure about change,
- ‡ and finally into a mode of readiness for change.

Health care practitioners must remember change is difficult, change takes time and ambivalence is normal. They should not expect immediate results. The goal of motivational interviewing is not to have a patient “see the light” and initiate immediate change, but to move from one stage of change to the next. For some children or parents, a health care visit based on motivational interviewing, is all that is needed to resolve the ambivalence and begin their process of change. Once they are “unstuck”, they mobilize their own resources and make changes. For other patients, motivational interviewing is the overture for more in-depth treatment. It opens the door for the necessary therapeutic work to be done in the future. When health care practitioners use motivational interviewing, it provides them with a strategy that is effective, increases patient satisfaction and decreases professional frustration.

Motivational Interviewing is a set of techniques that promotes behavior change using an empathic, respectful, patient-centered manner. A growing body of research demonstrates the efficacy of motivational interviewing as a useful strategy in helping patients acquire healthy behaviors. The active ingredients in promoting change have been summarized by Miller and Sovereign (1989) in the acronym FRAMES. In this guide it is suggested that the clinician use an abbreviated form of FRAMES called **TEAR** because this is easier to use in a brief intervention with children or adolescents in a busy clinical office.

Following is an example of how a health care practitioner would use the abbreviated motivational interviewing techniques called **TEAR** to help a young teenager who has begun to get into fights in school and whose father has an alcohol problem.

T teach

“Billy, it is okay to be concerned about a parent or another person’s alcohol or drug use. One of the most important initial things we can do is help you to learn more about how alcohol and drug use affect the individual involved such as your Dad, as well as how it affects yourself and others who live in the same house and care about him.”

E express empathy

“Billy, I’m concerned about what we just talked about and how it is making you feel. I’d like to help you so that you can feel better and resume getting the good grades that you used to get in school.”

A advise action

“Billy, I think it would be helpful for you to learn about alcohol and drug use and how it can affect everyone in the family. This will also help you learn other ways to deal with your frustration and anger. What are you willing to do?”

R reach agreement

“Billy, I’m glad you are willing to agree to talk with your school counselor in order to learn more about alcohol and drug use and to explore attending an Alateen meeting. I think this is great and I know you can be successful if you try this.”

(Source: Adger H, Blondell R, Cooney J, Finch J, Graham A, Macdonald DI, et al. *Helping Children And Adolescents In Families Affected By Substance Use*. Rockville, MD: Center for Substance Abuse Prevention, U. S. Substance Abuse and Mental Health Services Administration (Contract to American Academy of Addiction Psychiatry), 2000.)

Appendix IV

Resources for Children and Families

Referral sources for children and families affected by substance abuse vary by communities. Al-Anon, Alateen and school-base student assistance programs are often available. Family members can also be referred to a “family intervention specialist” or a mental health professional who has knowledge about the impact of substance use disorders on families.

Each U.S. State has an agency or department responsible for the alcohol/drug-related programs, resources, and initiatives offered throughout the State. States vary widely in the titles of these agencies and in their organizational affiliation within state government structures. In some instances, the addiction agencies are combined with mental health services. Many states also have resource centers with helpful free materials. To locate your state agency, look in your telephone directory under “State Government” listings or contact the **National Association of State Alcohol and Drug Abuse Directors, 807 17th Street, NW, Suite 410, Washington, DC 20006; phone 800-662-4357. Website: www.nasadad.org**

Alcoholics Anonymous (AA) is a voluntary fellowship open to anyone who wants to achieve and maintain sobriety and is an important adjunct to many treatment programs. Two individuals founded the fellowship in 1935 in an effort to help others who suffer from the disease of alcoholism. AA is the oldest of the organizations designed to help alcoholics help themselves. It is estimated that there are more than 2 million members in local AA groups worldwide. For further information, look under “Alcoholic Anonymous” in your telephone directory. **The Alcoholics Anonymous General Service Office can help in locating a nearby affiliate. Write to them at P.O. Box 459 Grand Central Station, New York, NY 10163 or phone 212-686-1100. Website: www.alcoholics-anonymous.org**

Al-Anon is an organization for spouses and other relatives and friends of alcoholics. The Al-Anon groups help families cope with the problems that result from another's drinking or drug use, and they help foster understanding of the alcoholic through sharing experiences. Local groups are listed in your telephone directory under “Al-Anon Family Groups.” **Al-Anon Family Group Headquarters can assist you in finding a local affiliate. Write to Al-Anon Family Group Headquarters at 1600 Corporate Landing Parkway, Virginia Beach, VA 23462; phone 1-800-356-9996 (Helpline: 1-800-344-2666). Website: <http://www.al-anon.org>**

Alateen, a part of Al-Anon, is for young people whose lives have been affected by the alcoholism of a family member or close friend. Members of Alateen fellowships help each other by sharing their experiences, hopes, and strength. Alateen is listed in some telephone directories, or information may be obtained by contacting local Al-Anon groups. If you are having trouble locating an Alateen affiliate near you, contact **Al-Anon Family Group Headquarters at the previously listed address. Phone 1-800-356-9996 (Helpline: 1-800-344-2666). Website: www.alateen.org**

Narcotics Anonymous (NA) is an international, community-based association of recovering drug addicts. Started in 1947, it sprang from the Alcoholics Anonymous movement. The NA movement is one of the oldest and largest of its type, with nearly twenty thousand weekly meetings in seventy countries. For more information, contact the **NA World Service Office, PO Box 9999, Van Nuys, California 91409, Telephone: (818) 773-9999, Fax: (818) 700-0700. Website: <http://www.na.org/> or <http://www.cerainc.com/na/5b.htm#21tag> for meetings throughout the U.S.**

The National Association for Children of Alcoholics (NACoA) is a membership organization and a clearinghouse for information and support materials for children of alcoholics and for those in a position to assist them. NACoA has videos, booklets, and newsletters and a kit for primary health care providers. For more information, contact the **National Association for Children of Alcoholics, 11426 Rockville Pike, Suite 100, Rockville, MD 20852; phone 301-468-0985 or 1-888-55-4COAS. Web site: www.nacoa.org**

Children of Alcoholics Foundation serves the children of alcoholics and other substance abusers. The foundation developed *Pandora's Box*, an educational tool to assist health care professionals in dealing with sensitive issues especially family alcoholism, child abuse and sexual abuse. For more information, contact the **Children of Alcoholics Foundation, 164 W. 74th Street, NY, NY 10023; phone:212-595-5810; fax: 212-595-2553; Email: coaf@phoenixhouse.org Website: www.coaf.org**

The National Council on Alcoholism and Drug Dependence (NCADD) is a nonprofit national voluntary health agency with several hundred local affiliates that are well acquainted with the problems of alcoholics and drug addicts and are dedicated to helping them. Information about addiction treatment opportunities is available through the local affiliates. In some instances, counseling of alcoholics and their families may be provided through the local unit, as well as support groups and other preventive interventions for children of substance abusers. Look for the listing of your local NCADD affiliate in the telephone directory. If you are having difficulty locating a unit near you, write to **NCADD at 12 West 21st Street, Seventh Floor, New York, NY 10010, or call 212-206-6770. Website: www.ncadd.org**

The National Association of Student Assistance Professionals (NASAP) is a non-profit organization, founded in 1987 by professionals who were concerned about the problems of student substance abuse, violence and academic under achievement. NASAP represents the interests of student assistance professionals across the U.S.. For information contact: **NASAP at 4200 Wisconsin Avenue, NW, Suite 106-118, Washington, DC 20016; phone 1-800-257-6310; fax 215-257-6997. Web address: www.nasap.org**

The National Clearinghouse for Alcohol and Drug Information is a supplier of relevant materials covering the entire gamut of alcohol- and drug-related issues. Its website has an extensive section for young people. Many materials are free and available to be ordered through an 800 number or over the Internet. For more information, contact the **National**

Clearinghouse for Alcohol and Drug Information, PO Box 2345, Rockville, MD 20852; phone 1-800-729-6686. Website: [http://www:health.org](http://www.health.org) Web address for children and youth: <http://www:health.org/kidsarea>

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) supports and conducts biomedical and behavioral research on the causes, consequences, treatment, and prevention of alcoholism and alcohol-related problems. NIAAA also provides leadership in the national effort to reduce the severe and often fatal consequences of these problems. *Alcohol Alert* is a free quarterly bulletin, which disseminates important research findings alcohol. NIAAA's address is 6000 Executive Boulevard, Willco Building, Bethesda, Maryland 20892-7003; phone 301-443-3860. Web site: www.niaaa.nih.gov

The National Institute on Drug Abuse (NIDA) has a mission of bringing the power of science to bear on drug abuse and addiction. NIDA supports and conducts research and ensures the effective dissemination and use of the results of research to significantly improve drug abuse and addiction prevention, treatment, and policy. *NIDA Notes*, the Institute's free bimonthly newsletter, covers research information. NIDA's address is: 6001 Executive Blvd., Bethesda, Maryland 20892; phone 301-443-6480. Web site: www.nida.nih.gov

Appendix V

Case Studies

The following case studies can be used for role-play or discussion. Practice asking the question, “Are you now or have you ever been concerned about someone in your family who is drinking or using drugs”. By the end of the role-play cover these other points:

1. There are lots of children in similar families—that they are not alone.
2. They did not cause the drinking or drug use or the consequent behaviors—it is not their fault.
3. Their concern is valid—that there is a problem.
4. There are resources where they can turn for help.

Remember to use the acronym TEAR (teach, express empathy, advise action, and reach agreement.)

These cases are formatted for a medical health care professional. Following the case are suggestions on how they can be changed for use by other professions.

Case Study I

Lee is 12-year-old who is brought to your office by Lee’s mother who is concerned about symptoms of fatigue. Lee is falling asleep in school. She wonders if Lee needs vitamins. While gathering additional information, you find out that Lee’s school performance is not as good as it has been in the past and that Lee has been getting into more fights at school recently. When asked if Lee gets enough sleep, Lee’s mother says that Lee goes to sleep very early. Lee mumbles, “It’s hard to sleep at our house”. You then see Lee alone. Find out why Lee has difficulty sleeping and if Lee is worried about anyone’s drinking or drug use. Lee wants to discuss this information with mom so that a plan can be made for help. A second role-play can be done with mom and Lee in which, you discuss the information you have obtained and make a plan.

(Directions for adapting this case to other disciplines.) A dentist could be seeing Lee for a check-up, a psychologist or social worker because of school problems, a physical or occupational therapist because of a chronic illness or birth defect. During the visit, you notice that Lee is yawning a lot and you ask about sleep. Lee’s mother may or may not be in the room, depending on what is usual for your setting. You can then ask about sleep and continue on with the role-play as written.

Case Study II

You are Robin's primary care provider. Robin is a 16-year-old who is seeing you today to have stitches removed from her/his forehead and arm. Since you had not put in the stitches, you ask how Robin was injured. With somewhat of a chagrined look, Robin admits that the injury occurred in a motor vehicle. Robin was driving, was alone and was returning from a new friend's home. You are concerned that alcohol may have been involved in the accident. After some transitional comments, ask the CRAFFT. Discuss the results of the CRAFFT and make a plan. Robin's mother is in the waiting room.

(Directions for adapting this case to other disciplines.) When Robin comes in to see you for a reason that would be appropriate for your discipline, you notice that Robin has stitches on her/his forehead and arm. You ask about them and find out Robin was in an accident while driving. You wonder if Robin had been using alcohol or drugs. Ask some general questions about the accident and then try the CRAFFT. Practice using the acronym TEAR (teach, express empathy, advise action, and reach agreement). Also, remember issues of confidentiality. Do not make promises that you cannot keep.

Module VII: Identifying and Assisting Children of Substance Abusing Parents



Project MAINSTREAM
Revised 10/05

1

Learning Objectives

Health care professionals will be able to:

- ◆ Cite evidence of substance use disorders in families
- ◆ Discuss the concept of resilience
- ◆ Discuss the impact on children and adolescents

2

Learning Objectives (continued)

Health care professionals will be able to:

- ◆ Ask about concerns and discuss parental substance use disorders with young patients
- ◆ Screen adolescents for substance use disorders
- ◆ Discuss the importance of cultural influences

3

Children Suffer From Parental Substance Abuse

- ◆ One in four children (28 million) under 18 are exposed to alcohol abuse or dependence in their families.
- ◆ At some time in their lives, 43% of children live with one or more adults with a substance abuse disorder.

(Grant, 2000)

4

Families



5

Risk Factors

- ◆ Indicators for potential problem occurrence or vulnerability
- ◆ Characteristics that occur more often for those who develop substance use problems

(NIDA, 1997)

6

Some at High Risk Don't Develop Substance Use Disorders

- ◆ Although considered high risk, many children grow up without developing consequences.
- ◆ Protective Factors shield against risk, but science does not explain how.
- ◆ There is no causal relationship between risk and protective factors.

Protective Factors

- ◆ Presence of positive influences
- ◆ Not merely absence or opposite of risk factors
- ◆ Meaningful only in the presence of some risk factors

(NIDA, 1997)

8

Protective Factors

(continued)

◆ Individual Factors

- Positive sense of self
- Good problem solving skills

◆ Family Factors

- High level of warmth
- Absence of severe criticism
- High parental expectations
- Clear rules
- Maintaining family rituals

Protective Factors

(continued)

◆ Peer Factors

- Positive peer group activities
- Positive peer group norms

◆ School Factors

- High expectations
- Clear standards
- Clear rules for appropriate behavior

10

Protective Factors

(continued)

◆ Community Factors

- Caring and support
- Opportunities for participation

◆ Societal Factors

- Counteradvertising
- Decreased substance accessibility

Resiliency

- ◆ Successful adaptation despite exposure to risk and adversity

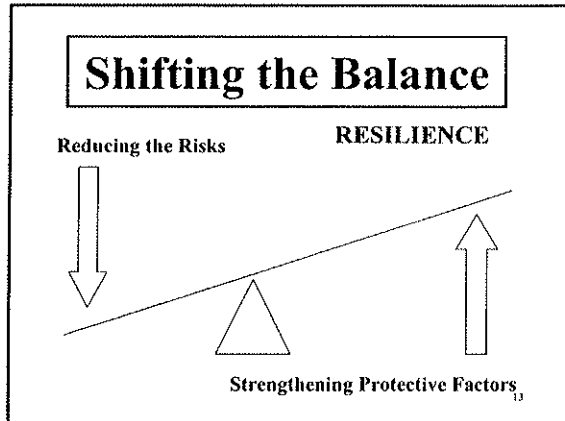
(Wolin & Wolin, 1995)

- ◆ Positive aspects of life that buffer

Risk factors, i.e. family rituals

(Steinglass, 1987)

12



Prevention Messages

- ◆ Inform children of risk or vulnerability
- ◆ Encourage families to develop protective factors
- ◆ Shame silences families, but they want clinicians to ask and to help
(Graham et al., 1994)

Alcohol Prenatal Risk

- ◆ Fetal Alcohol Syndrome, Alcohol Related Neurodevelopmental Disorder, Alcohol Related Birth Defects
- ◆ Psychological, cognitive and social problems without criteria for FAS
(Roebuck et al., 1999)

Alcohol Genetic Risk:

Children and first-degree relatives of alcoholics are 4 to 9 times more likely to develop an alcohol use disorder

Study	Sample	Ratio
Goodwin, et al., 1973	Copenhagen: 5,483 non-family cases, 1924-47	3.6: 1
Cloninger, et al., 1981	Sweden: 862 males adopted by non-relatives (Type I)*	4.4: 1
Cloninger, et al., 198	Sweden: 862 males adopted by non-relatives (Type II)**	9.4: 1
Bohman, et al., 1981	Sweden: 913 women adopted by non-relatives	3.5: 1
Numberger, et al 2004	United States: 8296 first-degree relatives of alcoholic probands	6.0: 1

* Type I: (milieu-limited) Mild parental alcoholism, mild parental criminality
**Type II (male-limited) Early onset severe alcoholism and serious criminality

Alcohol Genetic Risk (continued)

- ◆ Adoption does not eliminate genetic risk
(Goodwin et al., 1973)
- ◆ Low level of response to alcohol may explain relationship between family history and alcohol problems
(Schuckit, 1998)

Environmental Risk

- ◆ Living in alcoholic families is stressful for family members
(Jackson, 1954)
- ◆ Role modeling of alcohol and drug use
(Hawkins et al., 1992)
- ◆ Permissive attitudes toward alcohol and drug use
(Hawkins et al., 1992)

Consequences for Children of Alcoholics

- ◆ Psychiatric problems in adolescents
(Lynskey et al., 1994)
- ◆ More illness, injuries, poisonings, substance abuse, hospitalizations
(Woodside et al., 1993)

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Consequences for Children of Alcoholics (continued)

- ◆ More absenteeism from school, less help with homework
(Kumpfer, 1993)
- ◆ Subclinical health, social and adjustment problems
(Bennette et al., 1987)

20

In Nuclear Families With an Alcoholic Father

Parents exhibit:

- ◆ Antisocial behavior and depression
- ◆ Increased aggression between partners
- ◆ Less sensitivity towards infants
- ◆ Lower positive engagement with infants
(Leonard et al., 2000)

21

In Nuclear Families With an Alcoholic Father (continued)

- ◆ Infants are seen as difficult by their fathers
- ◆ Mothers have fewer verbal interactions with their infants
- ◆ Overall parenting patterns of infant avoidance
(Leonard et al., 2000)

22

During Young Adulthood

- ◆ As they left home children of alcoholics:
 - experienced more conflicts with parents and had more negative feelings
 - were more likely to return home to live
(Leonard et al., 2000)
- ◆ Daughters of alcoholics more likely to marry alcoholic men
(Shuckit, 1994 and Olmsted, 2003)

23

Adult Relationships

- ◆ Children of Alcoholics were:
 - less likely to marry
 - more likely to be unhappy in their marriages
 - more likely to divorce
 - more likely to marry a substance abuser.
(Walt, 2002)

24

Adult Children of Alcoholics

- ◆ Women scored significantly worse on:
 - social adjustment,
 - depressed mood, and
 - life satisfaction measures. (Griffin, 2005)
- ◆ Men reported lower levels of educational attainment
- ◆ Men and women reported lower levels of self-esteem. (Watt, 2002)

25

Nicotine Dependence

- ◆ Adult Children of Alcoholics:
 - Have an increased risk of nicotine dependence.
 - Start regular tobacco use about a year and a half earlier than non-COAs (Cuijpers & Smit 2002)

26

Genetic Transmission of Drug Disorders

- ◆ Genetics contribute to progression from use of cocaine or marijuana to dependence on those drugs. (Prescott & Kendler, 1998)
- ◆ Genetic factors are stronger in males than in females. (van den Bree et al., 1998)
- ◆ Heroin greater genetic influence (Tsuang et al., 1998)

27

Children of Drug Dependent Parents

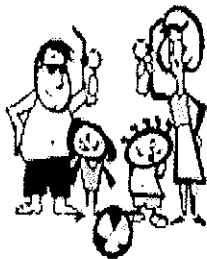
- ◆ Show a pattern of early hostility
- ◆ Associate with deviant peers
- ◆ Have a negative perception of home atmosphere that may lead to addiction (Nurco et al., 1999)

28

Chronically Stressed Family Roles

No scientific basis for family roles such as:

- chief enabler,
- family hero,
- scapegoat,
- lost child,
- clown.




29

Racial and Ethnic Differences

- ◆ Paucity of studies on minority children
- ◆ Rare to compare white and nonwhite children in the same study
- ◆ One study found that black daughters of alcoholics had similar problems as white daughters (Brisbane & Stuart, 1985)
- ◆ With limited comparison studies, cannot be sure models are applicable to minorities

30

Cultural Competence



Even though there is a paucity of research, health care professionals need to be sensitive to cultural issues which affect families.

31

Consequences for Family Members

- ◆ More visits to primary care physician for stress related illnesses
- ◆ More psychotropic medications

(Frank et al. 1992)


32

Clinical Presentation of Children of Alcoholics

- ◆ Sleep problems
- ◆ Gastrointestinal problems
- ◆ Headaches
- ◆ Musculoskeletal pain
- ◆ Enuresis
- ◆ Vague symptoms such as, weakness, dizziness, fatigue or appetite loss
- ◆ Accidents, injuries and poisonings
- ◆ Most often present with NO symptoms

(Baird, 1992)

The majority of Children of Alcoholics Are Not Identified and Assisted.



34

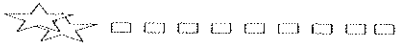
Reluctance to Ask About Family Problems

- ◆ No negative reactions by parents when children asked (Duggan et al., 1991)
- ◆ Patients wanted physicians to ask about family alcohol problems (Graham et al., 1994)

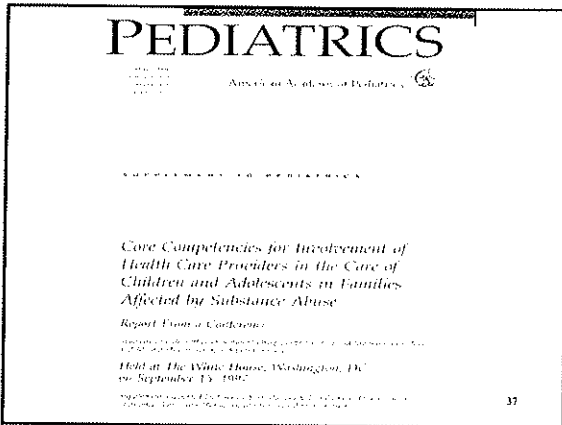
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helping children and adolescents in FAMILIES AFFECTED BY SUBSTANCE USE

CSAP <small>Center for Substance Abuse Prevention</small>	NACoA <small>National Association for Children of Alcoholics</small>
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36



Core Competencies

Level I

- ◆ Be aware of medical, psychiatric, and behavioral syndromes and symptoms
- ◆ Be aware of benefit timely and early intervention
- ◆ Be familiar with community resources

(Adger et al. *Pediatrics*, 1999;103(103):1083)

38

Core Competencies (continued)

Level I (continued)

- ◆ Include appropriate screening for family AOD use
- ◆ Determine family resource needs and services being provided
- ◆ Communicate appropriate concern and offer information, support and follow up

(Adger et al. *Pediatrics*, 1999;103(103):1083)

Health Care Practitioners Need to Ask and Screen for Substance Use in the Family

helping children and adolescents in

FAMILIES AFFECTED BY SUBSTANCE USE

CSAP Center for Substance Abuse Prevention	NACoA National Association for Children of Alcoholics
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40

Expected Outcomes

Children or adolescents will understand:

- ◆ They are not alone.
- ◆ It is not their fault.
- ◆ Their concern is valid.
- ◆ There is help available.

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Despite feeling a responsibility to inquire about AOD in patients and families there appears to be a cultural ambivalence and a lack of skills in doing so.

**Algorithm from
*Helping Children and
Adolescents in Families Affected
by Substance Use***

(Adger et al., 2000)

43

**The Most Important Question
You Never Asked**

**Have you ever been concerned
about the drinking or drug use of
someone in your family?**

44

**The Most Important Question
You Never Asked (continued)**

To whom? Parent(s) and/or children either alone or together.

When? At all health maintenance visits including any initial or pre-natal visits.

How? May be a part of a written questionnaire and/or a verbal history taken by health care practitioner or staff member.

Why? To set the groundwork for possible later discussion.

The Answer: No

1. No further action at this time. Repeat the question in one year or if circumstances suggest earlier intervention.
2. Prevention message: I'm happy you don't have this concern. Please let me know if it ever changes.

46

The Answer: Uncertain

Especially if body language suggests discomfort with the question, such as a furtive look to a parent, or hesitation occurs...

Consider these responses:

- ◆ An initial question such as: "Can you tell me more about your concern?"

47

**The Answer: Uncertain
(continued)**

- ◆ "Many of my patients are concerned about family member or a close friend who is drinking or using drugs, but are afraid to talk about it. Perhaps you'd like me to explain more about this sometime."

48

The Answer: Uncertain (continued)

- ◆ “Well, if you are ever concerned, will you please let me know?”
- ◆ Make a notation on the chart to re ask the question at a later visit.

49

The Answer: Yes

The clinician should actively listen for whether the family substance abuse is related to:

1. A persistent or ongoing illness, injury or health concern

- a. **Initial Response:** *“Tell me more about it.”*

50

The Answer: YES (continued)

b. Concluding Statements:

“Drinking or drug use by a family member can be harmful to a child’s health. Let me give you some information...”

and/or *“Maybe we should continue to talk about this”*

and/or *“I would be happy to refer you to someone who is knowledgeable about alcohol and drug use.”*

Offer a pamphlet and make a note on the chart.

The Answer: Yes (continued)

2. Child Abuse or Domestic Violence

Ask self, *“Is there a potential for child abuse or neglect?”* If yes or you are suspicious consider a referral of the child to protective services.

3. Child’s Own Substance Use

Determine the nature of the substance use and whether to refer the child for specialized treatment.

52

Helping Patients and Families Change

To help patients change, health care practitioners should:

- T** Teach
- E** Express empathy
- A** Advise action
- R** Reach Agreement

53

Change is Difficult

Health care practitioners use motivational interviewing to:

- ◆ Move patient from not being ready
- ◆ To being unsure about change
- ◆ Into mode of readiness for change

54

Adolescent Substance Use

- ◆ In 2003, 36% of 9th graders and 56% of 12th graders had at least one alcoholic beverage in the past 30 days; 20% of 9th graders and 37% of 12th graders drank 5 or more at one occasion.

(Grunbaum, 2004)

- ◆ Adolescents drink less often, but consume as much alcohol per occasion as adults

(Langenbucher et al., 2000)

- ◆ Adolescents who develop problems usually proceed from alcohol to cannabis and on to other illicit substances.

(Deas et al., 2000)

55

Adolescent Substance Use

(continued)

- ◆ Dependent adolescents have substantial rates of mood and comorbid conduct disorder

(Deas, et al., 2000)

- ◆ If adolescents expect positive effects from drinking, they are more likely to initiate drinking earlier and to drink more heavily.

(Dunn and Goldman, 1998)

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Assessing Adolescent Patients

- ◆ **Personal factors:** signs of conduct or mood disorders, risk taking, aggressive or hostile behaviors
- ◆ **Family factors:** history of addiction, family attitude towards alcohol and drug use, neglect and abuse

57

Assessing Adolescent Patients

(continued)

- ◆ **Peer involvement:** amount of alcohol or types of drugs they use
- ◆ **School factors:** low achievement or learning problems
- ◆ **Adolescent's history of use:** age at initiation, pattern, type and amount and signs of dependency

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CRAFFT

- C** Have you ever ridden in a **CAR** driven by someone (including yourself) who was high or had been using alcohol or drugs?
- R** Do you ever use alcohol or drugs to **RELAX**, feel better about yourself?
- A** Do you ever use alcohol or drugs while you are by yourself **ALONE**?
- F** Do you ever **FORGET** things you did while using alcohol or drugs?
- F** Do your **FAMILY** or **FRIENDS** ever tell you that you should **CUT** down on your drinking or drug use?
- T** Have you ever gotten into **TROUBLE** while you were using alcohol or drugs?

Score: 2 or more yes answers indicate a problem for follow-up.
(Knight et al., 1999)

Identifying Resources

- ◆ State Agencies
- ◆ Alcoholics Anonymous (AA)
- ◆ Al-Anon
- ◆ Alateen
- ◆ Narcotics Anonymous (NA)
- ◆ The National Association for Children of Alcoholics (NACoA)
- ◆ Children of Alcoholics Foundation (CAF)

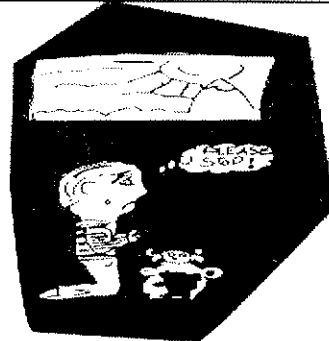
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Identifying Resources (continued)

- ◆ The National Council on Alcoholism and Drug Dependence (NCADD)
- ◆ The National Association of Student Assistance Professionals (NASAP)
- ◆ The National Clearinghouse for Alcohol and Drug Information
- ◆ The National Institute on Alcohol Abuse and Alcoholism (NIAAA)
- ◆ The National Institute on Drug Abuse (NIDA)

61

We must be child health advocates!



62

Summary

According to National Association for Children of Alcoholics:

- ◆ 43% of the U.S. adult population, have been exposed to alcoholism in the family
- ◆ Almost one in five adult Americans (18%) lived with an alcoholic while growing up.

63

Summary

(continued)

- ◆ While the majority of Children of Alcoholics will grow up to lead healthy and productive lives, many will not
- ◆ The challenge before us is to identify those who need help early and intervene in a timely and meaningful manner

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