Helping children and adolescents in Families Affected by Substance Use

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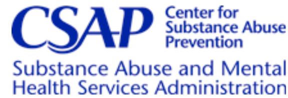

National Association for Children of Alcoholics

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Key Points

- Approximately one in four children in the United States is exposed to family alcohol abuse or alcohol dependence.
- The large number of children affected defines one of today's major health problems.
- There are biological, psychological, behavioral, and social consequences of alcohol and drug exposure.
- All of these children are at risk of adverse developmental, social, and health outcomes.
- Health care practitioners have an important opportunity to help children and adolescents.

This guide presents information and tools to help health care practitioners ask questions and intervene with patients and families.

Importance of the Problem
Why bother?

Key Points

- Approximately one in four children is exposed to family alcohol abuse or alcohol dependence.
- Health care costs are higher for these children.
- Family modeling of drug use is related to an increased risk of drug problems.
- There is a strong genetic component in family alcohol dependence.
- These children are more apt to be abused and to exhibit depression and anxiety.
- These children are more apt to score lower on measures of verbal ability. They are also more apt to be truant and drop out of school.

Because of its prevalence and lack of socio-economic boundaries, child health care practitioners should expect to encounter families affected by alcohol and drug abuse daily.

There are more than 28 million children under the age of 18 in the United States who are exposed to family alcohol abuse or alcohol dependence.[1] This figure is magnified by a significant number of children who are affected by families impaired by other psychoactive drugs. Many of the children exposed to substance (alcohol, tobacco and other drugs) use are also exposed to chaotic environments that lack consistency, stability and emotional support. Many will be resilient and enter adulthood as productive individuals, but some will develop substance use problems and/or serious coping problems. Health care practitioners can have a major influence on families who misuse alcohol, tobacco, and drugs because the practitioners have a long-standing relationship with the family and are in an excellent position to understand the family dynamics that influence these behaviors. As a clinician, you will usually be dealing with the child's perception of the problem, rather than the parent's substance use.

Important Facts Regarding Children in Families Affected by Substance Use Disorders

- Approximately one in four children younger than 18 years in the United States is exposed to alcohol abuse or alcohol dependence in the family.[1]
- Children of alcoholics (COAs) experience higher health care costs than children from non-alcoholic families. Total health care costs are 32 percent greater for children of alcoholics. COAs are admitted to the hospital 24 percent more often, stay 29 percent longer, and have 39 percent higher in-patient hospital costs.[2]
- Family modeling of drug using behavior and permissive parental attitudes toward children's drug use are family influences related specifically to an increased risk of alcohol and other drug abuse by the children.[3]
- Children living with an active alcoholic score lower on measures of family cohesion, intellectual achievement, recreation, and independence. These children usually experience higher levels of conflict within the family and are hampered by their inability to grow developmentally in healthy ways.[4]
- Strong scientific evidence indicates that substance use disorders have a strong genetic component and tend to cluster in certain families. Up to 25 percent of children of alcoholics will become alcoholics themselves.[5]
- A relationship between parental alcoholism and child abuse is indicated in a large proportion of child abuse cases.[6]
- Children of alcoholics (COA's) exhibit symptoms of depression and anxiety more than children from non-alcoholic families.[7]
- Children of alcoholics score lower on measures of verbal ability than children from non-alcoholic families. COAs are more likely to be truant, drop out of school, repeat grades, and be referred to a school counselor. They have greater difficulty with abstraction and conceptual reasoning.[7]

The Call to Action
What you can do

Key Points

- Listen and ask questions.
  Provide support and validation for patients' concerns.
- Help educate patients and families about substance use and its impact on the family.
- Take an active anticipatory role in guiding patients and families to available resources.
- Help connect patients and families to specialists when needed.
- Strive to achieve Level I of the *Core Competencies for Involvement of Health Care Providers in the Care of Children and Adolescents in Families Affected by Substance Abuse.*

Routine screening for children affected by family substance use disorders must occur at all ages across infancy, childhood and adolescence.

Role of the Health Care Provider

Health care providers can make a significant difference in the lives of children and adolescents living in families affected by substance use disorders. Health care providers need to take advantage of the opportunity afforded by the special nature of the relationships they have with families. In this way, they will improve on what they do best:

- Listen and ask questions.
- Provide support and validation for the patients' concerns.
- Help educate patients and their families about substance use disorders as a disease that affects the entire family.
- Take an active anticipatory role in guiding patients and families to available resources.
- Help connect patients and their families to specialists and consultants when needed.

One study indicated that fewer than half of pediatricians asked about problems with alcohol when taking a family history. Such a family history of alcohol and other drug abuse is more likely than many aspects of history to affect a child's immediate and future health.[8]

Information about family alcohol and drug use should be obtained as part of routine history taking when there are indications of:

- family dysfunction;
- child behavior or emotional problems;
- school difficulties;
- recurring episodes of apparent accidental trauma; and
- recurring or multiple vague somatic complaints by the child or adolescent.

In many instances, family problems related to alcohol or drug use are subtle; their identification requires a deliberate and skilled screening effort. **(See Tool 3, Screening and Brief Intervention Information.)**

Introduction to the *Core Competencies*

Using preventive interventions with adolescents and their families has become increasingly more important. These interventions strengthen families and maximize opportunities for health care providers to enhance the health and welfare of children. The *Core Competencies for Involvement of Health Care Providers in the Care of Children and Adolescents in Families Affected by Substance Abuse* is a statement that articulates three distinct levels of care. **(See Core Competencies**.) The *Core Competencies* attempt to recognize and account for individual differences and desired levels of

involvement among health providers. It specifically calls for a minimal role for all primary health care providers but provides enough flexibility for providers to choose their role and degree or level of involvement. Further, it recognizes a central tenet that, while health care providers must be responsible for identifying the problem, they are not expected to solve, manage or treat the problem all by themselves.

Level I of the Core Competencies

All primary health care providers with responsibility for the care of children and adolescents, regardless of their specific area of training or discipline should, at a minimum, have the knowledge and skills to practice at **Level I**. This includes:

- a basic understanding of the medical, psychiatric and behavioral symptoms of children and adolescents in families affected by substance use disorders;
- familiarity with local resources;
- routine screening for family history/current use of alcohol and other drugs;
- determination of whether family resource needs and services are appropriate; and
- ability to express an appropriate level of concern and offer support and follow-up.

The specific knowledge and skills indicated in **Level I** of the *Core Competencies* are suggested as a baseline or minimal level of competence that all primary health care providers should strive to achieve. The role of the health care provider is that of initiating an inquiry about and validating an important health problem for which the appropriate care could dramatically improve patients' well being. It is not the intention of the *Core Competencies* to burden the busy health care provider with attempting to solve complicated family and behavioral issues which have evolved over long periods of time.

Some Still Want to do More

The statement of the *Core Competencies* recognizes that some will want to do more. For those who wish to do more and be involved at a deeper level, a different and more advanced set of knowledge and skills will be required. Most important, this is a decision that each provider can make for her/himself. Some will want to attain these additional knowledge and skills while most will be able to collaborate with and refer to those who have the skill and expertise to provide these more specialized services. The end result, however, will be increased attention to an important problem and enhanced opportunities for validation, education, support and treatment for patients and families affected by substance use disorders. In short, the *Core Competencies* are a vehicle for helping us to brighten the future for children who may be struggling with one of the families' biggest and most burdensome secrets.

Expected Outcomes

Key Points

Children or adolescents will understand:

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

Appropriate questions will identify children and adolescents who are in families affected by substance use problems. An expression of care and concern by the health care practitioner can comfort and provide hope to the child or adolescent who suffers under the fallout from another's alcohol or drug problem. The attentive clinician may also be able to initiate a series of events that eventually leads the individual with a substance use problem to sobriety and recovery, and 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 mitigate the negative effects of life in a chaotic home environment and improve outcomes. Clinicians who ignore the obvious signs of distress in a child or adolescent that come from living with an alcoholic or drug addicted parent, 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.

Those clinicians who follow the suggestions in this guide will avoid this mistake and can expect to find the positive outcomes outlined below.

Positive Outcomes

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; this adds to their feelings of isolation and shame. The clinician validates and normalizes the child's and adolescent's perception that "something is wrong" at home and helps them to understand that they are not alone.

2. ***The children or adolescents will understand that they did not cause the drinking or drug use or the consequent behaviors — that it is not their fault.*** They need to learn that they did not cause the substance use problem or disorder, that they cannot cure it, but that they can learn to better care for themselves so that they can lead a healthier, happier life. Children and other non-addicted 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 maladaptive 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 young people who live with alcohol or drug use problems have no idea where to go for help. The clinician can quickly remedy this situation by providing addresses, telephone numbers, Web sites and contact people. Children and adolescents may be referred to self-help groups such as Alateen, school counselors or school-based student assistance programs or treatment centers that offer services for young people who are affected by somebody else's alcohol or drug problem.

Clinical Algorithm

The most important question some NEVER ask

The Question: "Have you ever been concerned about someone in your family who is drinking alcohol or using drugs?"

No

1. *No further action at this time*. Repeat the question in one year or if circumstances suggest earlier intervention.
2. *Prevention Message*: "That's good. The reason I ask is that many of my patients are concerned about someone in the family but are uncomfortable about discussing it. Please let me know you ever have these concerns."

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 me to talk more about this some other time."
3. "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.

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: "Alcohol or other drug use can affect a child's health in many ways. 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 the enclosed pamphlet or other information 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 violence, 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 of the substance use and whether to refer the child for specialized treatment.

Clinical Algorithm

The most important question some NEVER ask

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 of responses:

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 kids have to deal with this problem too.
- Tell her that it is not her fault, and give her the pamphlet with this kit.
- Ask her if she would like you to talk with her parents.
- Give her other printed information, Web sites and phone numbers.
- 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 pamphlet in this kit and/or other printed information, Web sites, and phone numbers.
- Consider a referral to child protective services if you suspect abuse or neglect.

Core Competencies

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 which 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.

Core Competencies

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.

Helping Patients and Families Change

Key Points

To help patients change, health care practitioners should:

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

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 that 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 motivated, 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[9] 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. The longer FRAMES is included in the Tools section of this guide.

(See Tool 1, FRAMES and Tool 2, Basic Principles and Rationale for Motivational Enhancement.)

Helping Patients and Families Change

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, you know 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. You can talk to the counselor at your school or attend meetings of a group called Alateen in order to learn about the disease of alcoholism and learn other ways to deal with anger.

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."

Setting Up The Office

To help ask the question

Key Points

- Discuss with office team and obtain support.
- Educate and train staff.
- Clarify the process to be used.
- Designate responsible person.
- Select educational materials.
- Implement the system.
- Have follow-up meetings.

It is important to set up procedures in the office that are supportive of the clinicians and reinforce asking the question about family substance use. Studies show that new goals are more likely to be achieved if the office system supports and facilitates them.

Step One: Educate and Obtain Commitment of the Office Staff

- Discuss the algorithm for "asking the question" presented in this guide with all members of the office team to gain their understanding and support.
- Educate the staff about the family dynamics of substance use disorders. Health care practitioners can explain such concepts as: 1) When one member of the family has a substance use disorder, all the members of the family can be affected. 2) Children often suffer in silence, and denial can prevent the unaffected parent from obtaining help. 3) No one in the family may understand that alcohol and or other drug addiction is a disease and that treatment is available; or 4) a family may be too ashamed to ask for help.
- Train the clinicians to ask the question: "*Have you ever been concerned about someone in your family who is drinking alcohol or using drugs?*" Have them practice with one another.
- Clarify the process to be used including staff responsibilities and locations for materials.
- Brainstorm roles, needs, and impediments to implementation of these procedures and find solutions.
- Designate one staff member to be responsible for establishing and maintaining the system. This person will become the "champion" for implementation of the health care activities presented in this guide and could be a receptionist, nurse assistant, nurse practitioner, physician assistant, or office manager.
- Meet with staff on a regular basis for the first six months to discuss problems and give feedback as the team implements these activities.

Setting Up The Office
To help ask the question

Step Two:
Select Appropriate Materials for the Office

There are several ways to provide educational materials:

- Select magazines, self-help pamphlets, and posters that are appropriate for the waiting room area and examining rooms.
- Select magazines about health and/or ones that do not carry advertisements about alcohol or tobacco.
- Consider use of videotapes to provide educational material for children and families while they are waiting in the reception area for an appointment. These could include substance use disorder prevention programs or self-directed assessment programs.
- Post a list of community-based prevention and treatment activities (which may be available from a community agency) on a bulletin board in the waiting room. A list of self-help group meetings (AA, Al-Anon, Alateen) may also be helpful to patients or family members who are looking for help but may be too ashamed or afraid to ask the health care practitioner directly.
- Collect materials and make them available to families. These can be ordered free or at low cost. **(See Tool 6 NACoA Order Form; and Tool 7, National Clearinghouse; and brochure, *It's Not Your Fault.*)** Make sure there is a system for ordering and replacing the materials so they are always available to the health care practitioner when needed.

Identifying Resources

Where to Get Help

- Family members, other relatives and friends.
- Al-Anon, Alateen or AA.
- School resources (nurses, counselors, social workers, teachers).
- Pastoral counseling or other supports available through churches.
- Support through therapeutic relationships.
- Youth groups and youth workers.

Local Resources

Once a clinician has identified an individual or family member as being affected by the consequences of living with or caring for an alcoholic or drug abusing family member, it is important that the clinician be able to provide access to appropriate resources. There are resources available to provide information, support or treatment if needed.

Optimally, the clinician should have an idea of what level or kinds of support are needed and then direct the family appropriately. At a minimum, this may simply be access to more information, so that the individual or family can sort out for themselves, what help they need. Most dramatically, emergent referrals may be necessary for safety if there is evidence of acute danger from physical abuse. In addition, referral options for substance abuse treatment may be needed for the alcohol or drug dependent family member. Also, referrals for mental health treatment may be needed for one or more of the family members as a result of the emotional consequences (e.g., depression, anxiety) of living with a person who has substance use problems.

In addressing the needs of the family, the clinician may want to explore what resources the family can identify for themselves within their own support network.

These resources include:

- Family members, other relatives and friends
- Al-Anon, Alateen, or AA
- School resources (nurses, counselors, social workers, teachers)
- Pastoral counseling or other supports available through churches
- Support through therapeutic relationships
- Youth groups and youth workers

Finally, in exploring options that involve referral for treatment, the person's insurance status, ability to pay out of pocket, or limitations placed by managed care arrangements will have to be considered. To have ready access to information regarding local resources, the clinician should consider filling out the **Local Resources Worksheet (see Tool 5)**, or having a staff member or mental health colleague fill it out and keep it readily available in the clinical area.

National Resources

Primary care practitioners often know the best local referral sources for individuals and families impacted by alcohol or other drug problems. If additional resources are needed, office staff may wish to contact the following state or national resources for more information. In the case of a family member who is seeking help for a drinking spouse or parent, encourage them to participate in Al-Anon or Alateen and or help them to find a substance abuse treatment specialist. Parents and youth can also be referred to the resources listed below.

State Agencies Each state has an agency responsible for alcohol/drug-related programs and resources. States vary widely in the titles of these agencies as well as where they are located within state government. In some instances, the substance abuse agencies are combined with mental health services. Many states also have resource centers with helpful free materials. To locate the state agency, look in the phone 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. Web site: www.nasadad.org

Identifying Resources

The National Association of Student Assistance Professionals (NASAP) is a non-profit organization founded in 1987 by professionals who where concerned about the problems of student substance abuse, violence, and academic underachievement. NASAP represents the interests of student assistance professionals across the United States. For information contact **NASAP, 4200 Wisconsin Avenue, NW, Suite 106-118, Washington, DC 20016; phone 800-257-6310; fax 215-257-6997. Web site: www.nasap.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 substance users and are dedicated to helping them. Information about 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 services for children of substance abusers. Look for the local NCADD affiliate in the phone directory. Or write to **NCADD, 12 West 21st Street, Seventh Floor, New York, NY 1001; phone 212-206-6770. Web site: www.ncadd.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 AA in 1935 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 "Alcoholics Anonymous" in the telephone directory. **The AA 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; phone 212-686-1100. Web site: 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, and they help foster understanding of the alcoholic through sharing experiences. Local groups are listed in the telephone directory under "Al-Anon Family Groups." Al-Anon Family Group Headquarters can assist in finding a local affiliate. Write to **Al-Anon, at 1600 Corporate Landing Parkway, Virginia Beach, VA 23462; phone 800-356-9996 (Helpline: 800-344-2666). Web site: 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 groups help each other by sharing their experiencees, hopes, and strength. Alateen is listed in some phone directories, or information may be obtained by contacting local Al-Anon groups. If there is difficulty locating a nearby Alateen affiliate, contact **Al-Anon Family Group Headquarters at the previously listed address; phone 800-356-9996 (Helpline: 800-344-2666). Web site: 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; phone 818-773-9999; fax: 818-700-0700. Web site: www.na.org/ or www.cerainc.com/na/5b.htm#21tag for U.S. meetings**

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. For more information, contact the **NACoA, 11426 Rockville Pike, Suite 100, Rockville, MD 20852; phone 301-468-0985 or 888-55-4COAS. Web site: www.nacoa.org (See Tool 6, NACoA Order Form)**

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**

The Center for Substance Abuse Prevention (CSAP)/Substance Abuse and Mental Health Services Administration (SAMHSA) provides national leadership in the federal effort to prevent alcohol, tobacco and illicit drug problems. CSAP fosters the development of comprehensive, culturally appropriate prevention policies and systems that are based on scientifically definsible principles and target both individuals and the environments in which they live. For more information, contact **CSAP, 5600 Fishers Lane, Rockwall II, 9th Floor, Rockville, MD 20857; phone 301-443-0365; fax 310-443-9140. Web site: www.samhsa.gov/csap**

The National Clearinghouse for Alcohol and Drug Information (a program of the U.S. Substance Abuse and Mental Health Services Administration) is a supplier of relevant materials covering the entire gamut of alcohol- and drug-related issues. Its Web site has an extensive section for young people. Many materials are free and can be ordered through an 800 number or over the Internet. For more information, contact **NCADI, PO Box 2345, Rockville, MD 20852; phone 800-729-6686. Web site: www:health.org; Web site for children and youth: www.health.org/kidsarea (See Tool 7.)**

Tool 1
FRAMES

Feedback

Providing patients with personal information regarding health status
"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 as well as others who may live in the same house and care about that person."

Responsibilty

Emphasizing the patient's freedom of choice and personal responsibility for change
"Billy, you need to know that you can't be responsible for changing other people's behavior, but you are in charge of your behavior."

Advice

Clearly recommending the need for change, conveyed in a supportive and concerned manner, rather than authoritatively
"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."

Menu

Providing a variety of options for change
"Billy, you can talk to the counselor at school or attend a group called Alateen in order to learn about the disease of alcoholism and learn other ways to deal with anger."

Empathy

Style of helping based on reflective listening, warmth, genuineness and respect
"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."

Self-efficency

Reinforcing the patients' expectations that they can change
"Billy, I am sure that if you make up your mind to learn about new ways to deal with your anger, you will be very successful in doing so."

Tool 2
Basic principles and rationale for motivational enhancement

The basic principles and rationale for motivational enhancement begins with the assumption that the responsibility and capability for change lie within the patient and/or involved family member. The clinician's task is to create a set of conditions that will enhance the patient's and/or involved family member's own motivation for and commitment to change. Your job is to mobilize their own inner resources as well as those inherent in their natural helping relationships. Miller and Rollnick (1991)[9] have described five basic motivational principles underlying such an approach, which can be used to lead patients and/or involved family members in initiating and complying with behavior change efforts.

Express Empathy. The clinician's role is to communicate great respect for the patient/family. It is a blend of support person and knowledgeable consultant for the benefit of the patient. The patient/families freedom of choice and direction and responsibility for change are respected. It is important to communicate to the child or adolescent that another person's drinking or drug use is not their fault and that they cannot be responsible for changing them. Supportive persuasion is gentle, subtle, and always with the assumption that change is up to the patient/family. The major role of the clinician is *listening rather than telling.* The power of such gentle, non-aggressive persuasion is widely recognized in clinical writings. Reflective listening is a key to motivational interviewing. It communicates an acceptance of where patients are, while also supporting them in the process of change.

Develop Discrepancy. Motivation for change occurs when people *perceive a discrepancy between where they are and where they want to be.* The motivational enhancement approach seeks to enhance and focus attention on such discrepancies with regard to the drinking or drug use behavior. In certain cases, it may be necessary to first develop such discrepancy by raising the patient/families' awareness of the personal consequences for family members related to the alcohol or other drug use.

Avoid Argumentation. The motivational enhancement style explicitly avoids direct argumentation, which tends to evoke resistance. No attempt should be made to have the patient admit or accept a diagnostic label. The clinician does not seek to prove or convince by force or argument. Instead, the clinician assists the patient/family in accurately seeing the consequence of the drinking or drug use. When used properly, *the patient/family and not the clinician voices the argument for change.*

Roll with Resistance. Motivational enhancement strategies do not meet resistance head-on, but rather "roll with" the momentum, with a goal of shifting patient/family perceptions in the process. Ambivalence is viewed as normal, not pathological, and is explored openly. Solutions are usually evoked from the patient/family rather than provided by the clinician.

Support Self-Efficacy. People who are persuaded that they have a serious problem will still not move toward change unless there is hope for change. Self-efficacy is a critical determinant of behavior change. Self-efficacy is, in essence, the belief that one can perform a particular behavior or accomplish a particular task (i.e., going to self-help group). In everyday language, this might be called hope or optimism. If one has little hope that things can change, there is little reason to face the problem. *The clinician can be a cheerleader and play an important role by providing the patient/family with hope and optimism.*

Tool 3
Screening and brief intervention information

Choosing Screening Questions

Choose interviewing or screening methods to identify substance users. A combination of self-administered questions and a direct practitioner interview presents the best screening strategy. The most important aspect in setting up a screening procedure is to make it simple and consistent with other screening activities that occur in the clinician's practice. Questions that focus on alcohol and drug consumption and/or concerns are recommended. The questions should be short and easy to ask or administer. The alcohol/drug questions could be included in an overall health-screening instrument for the practice or clinic. There are recommended screening questions for adolescents as well as adults. A few brief screening instruments follow.

Examples of Brief Substance Abuse Screening Instruments

CRAFFT for Adolescents[11]

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 or it in?

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.

CAGE-AID (The CAGE questions adapted to include drugs)

C Have you felt you ought to CUT down on your drinking or drug use?

A Have people ANNOYED you by criticizing your drinking or drug use?

G Have you felt bad or GUILTY about your drinking or drug use?

E Have you ever had a drink or used drugs first thing in the morning (EYE-OPENER) to steady your nerves, or get rid of a hangover, or get the day started?

Score: 1 or more yes answers indicate a positive screen and the need for further assessment and follow up.

Practice Brief Advice Intervention or Anticipatory Guidance

After the patient has been questioned or screened, the health care practitioner will want to give feedback to the patient. Although giving this brief feedback or advice is not difficult, health care practitioners are often uncomfortable discussing reductions in substance use. Health care practitioners are encouraged to practice the techniques presented in this guide with a colleague or staff member. It often helps to role-play asking questions and giving brief advice techniques in a controlled setting. Health care practitioners may want to attend workshops at national continuing education programs that teach how to use this technique. If no brief intervention advice is necessary for a child or family because there is not yet a problem with alcohol or drug use, it is often useful to give anticipatory guidance by presenting short messages that can prevent future problems. Also, *always leave the door open* by asking that the child let the health care practitioner know if ever there is a concern.

Tool 4
Referral and reminder system for the office

Develop Referral Methods

The designated staff person in charge of the office system can identify substance use disorder specialists and resources available for referral for children or their parents. Health care practitioners may want to identify counselors in their community to refer to or who might be willing to come to their office on a regular basis to conduct assessments and provide referral information. (**See Tool 5, Local Resources Worksheet.**)

Develop a Reminder System

A reminder system is necessary to label the medical records of patients who have shared worries about substance using family members or have completed screening procedures. They also remind health care practitioners about previous interventions. This system can identify at-risk substance users or families at each visit and provide a method for long-term follow-up. Computerized medical records may greatly facilitate the development of a reminder system for screening patients or follow-up on family worries. A manual tickler file system can also be implemented to provide a method to record each contact. For example, the reminder can indicate a need to ask the algorithm question again or follow-up on what the child told you in the previous contact. It can also remind you to screen the child for their own substance use or talk to or screen other family members.

Tool 5
Local resources worksheet

This worksheet should be filled out by a designated office staff person and made available to clinicians.

1. Local support groups

Phone numbers to identify contacts or meeting times for:
Al-Anon ______________________________
Alateen ______________________________
AA (Alcoholics Anonymous) ______________________
NA (Narcotics Anonymous) ______________________

2. Community Mental Health Services for Families and Children

It may be necessary to call and identify resources best suited for families or children dealing with alcohol-related issues. These may include classes, groups, or therapists available for individual or family counseling. Clarify if resources are available regardless of ability to pay and how to access services.

Agency ______________________
Address ______________________
Phone ______________________
Contact Person ______________________
Notes on access or financial issues __________
____
____

Agency ______________________
Address ______________________
Phone ______________________
Contact Person ______________________
Notes on access or financial issues __________
____
____

3. Substance Abuse Treatment Centers

For most patients with managed care insurance, treatment options available either for the alcoholic or the family members of the alcoholic will be dictated by the particular policy, and the patient may need to explore this themselves. However, it may be useful to have identified a program that has services targeted directly for family members and to have identified at least one well regarded treatment program for potential referral for evaluation and treatment of patients with substance use disorders.

Program Specifically for Family Members

Address ______________________
Phone ______________________
Contact Person ______________________
Notes on access or financial issues __________
____
____

Program Specifically for Persons with Substance Abuse Problem

Address ______________________
Phone ______________________
Contact Person ______________________
Notes on access or financial issues __________
____
____

Tool 5
Local resources worksheet

4. Individual Mental Health Therapists

Not all mental health therapists are experienced or interested in working with children or families with substance use disorders in the family. It may be necessary to question colleagues, call contacts within substance abuse treatment centers or have the patient check with their managed care referral systems. Ask about billing or insurance limitations.

Therapist ______________________________

Phone ______________________________

Address ______________________________

Notes on expertise, payment ______________

____

____

Therapist ______________________________

Phone ______________________________

Address ______________________________

Notes on expertise, payment ______________

____

5. Shelters for Emergent Referral

Clarify conditions for admission, limitations (e.g. are children allowed, what ages) and payment requirements, if any.

Domestic Violence Shelter ______________

Address ______________________________

Phone ______________________________

Notes ______________________________

Homeless Shelter ______________________

Address ______________________________

Phone ______________________________

Notes ______________________________

6. School Resources

Counselor/Social Worker ______________

Address ______________________________

Phone ______________________________

Notes ______________________________

____

Nurse ______________________________

Address ______________________________

Phone ______________________________

Notes ______________________________

____

Student Assistance Program ______________

Address ______________________________

Phone ______________________________

Notes ______________________________

Other Resources ______________________

Address ______________________________

Phone ______________________________

Notes ______________________________

Tool 6

Available from the National Association for Children of Alcoholics

You're Not Alone: A nine-minute video speaks directly to children and youth, and gives them information about alcoholism, being safe, finding adults who can help, and about group as a place to find support. Includes a discussion guide. $19.00

Kit for Kids: Written specifically for children and youth, this 8-page booklet includes factual information about alcoholism and being a child of an alcoholic, practical DOs and DON'Ts, phone numbers to call for help, and a list of books for further information. $1.00

Kit for Parents: Written for parents in families where there is alcoholism, this 14-page booklet offers facts about alcoholism, how to provide support to their children and help for themselves and their spouses, practical DOs and DON'Ts, and a list of resources for further information. $5.50

Children of Alcoholics: Selected Readings, Vol II: NACoA's 2000 publication of articles by leading authorities, both researchers and clinicians, covers a broad array of useful and reliable information with each author contributing a chapter. $14.95

RESILIENCE AND DEVELOPMENT: Positive Life Adaptation / Edited by Meyer D. Glantz, PhD and Jeannette L. Johnson, PhD: This volume is a compilation of many contributors who ask the question "Why do many people with all the risk factors fail to develop alcoholism, other drug addiction or other mental health problems?" It includes reviews by expert researchers examining critical aspects of resilience, as well as discussion and alternative perspectives. Retail Price $49.95 NACoA Price $35

Free brochures developed by the White House Office of National Drug Control Policy, Center for Substance Abuse Treatment, and NACoA that focus on encouraging young people living with addiction to talk with supportive adults:

Brochure: *You Can Help* is a guide for caring adults working with young people experiencing addiction in the family.

Brochure: *It's Not Your Fault* is the generic version of the brochure that is enclosed in this kit.

Item	Cost	Quantity	Total
(1) Video: *You're Not Alone*	$19.00		
(2) Kit for Kids	$1.00		
(3) Kit for Parents	$5.50		
(4) Children of Alcoholics: Selected Readings, Vol. II	$14.95		
(5) Resilience and Deveopment	$35.00		
(6) Brochure: You Can Help	FREE		
(7) Brochure: It's Not Your Fault	FREE		
Shipping Info: $3 for orders under $10, $4.00 or 10 percent of total invoice, whichever is greater, for orders over $10	Sub Total		
	MD Tax		
	Postage & Handling		
	Total		

Name ______________________________

Street Address ______________________________

City ______________ State ______________ Zip ______________

Telephone ______________________ Fax ______________

Please mail or fax your order to:
NACoA 11426 Rockville Pike, Suite 301, Rockville, MD 20852
Fax: (301) 468-0987 Phone: 888-55-4COAS (2627) • email: nacoa@nacoa.org • www.nacoa.org

Tool 7
SAMHSA's National Clearinghouse for Alcohol and Drug Information

SAMHSA's NCADI offers a broad range of information and prevention materials suitable for parents and children which could be used for handouts in your office. Materials include pamphlets, booklets, fact sheets, videos, research monographs and posters.

The NCADI Web site includes an extensive catalogue, updated regularly, as well as materials for children and adults in both English and Spanish that can be downloaded directly.

SAMHSA's National Clearinghouse for Alcohol and Drug Information

P.O. Box 2345
Rockville, MD 20847-2345
Fax: 301-468-6433
800-729-6686
1-800-487-4889(TTD)
www.ncadi.samhsa.gov

NCADI is part of the Substance Abuse and Mental Health Services Administration
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

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