

Disrupting the legacy of addiction

An Evaluation of the Betty Ford Children's Program

TREATMENT RESEARCH INSTITUTE

May 11, 2014

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Acknowledgements

This project would not have been possible without the cooperation of the program staff members at each of the Betty Ford Center Children’s Programs. Their help and kind assistance is deeply appreciated. We would also like to acknowledge the excellent work of the interviewers at the Treatment Research Institute and the editorial assistance of Ms. Brittany Bugbee. This project was funded through a grant from the Conrad Hilton Foundation.

Executive Summary

The Devastating and Radiating Effects of Parental Addiction

While it is well known that addiction can wreak havoc on the life of an individual, the serious impact on the lives of others is often less recognized. Addiction can have radiating effects on a person's entire family, undermining the normal day-to-day functioning of a household and impairing the ability of family members to effectively communicate with one another and solve even the most minor problems.

For a young child, living with a parent who has an addiction to drugs or alcohol can be confusing, scary, chaotic, and sometimes very lonely. National surveys tell us that at least 8.3 million children under the age of 18 currently live with a parent who abuses or is dependent upon drugs and/or alcohol. Children living in such families can be affected by parental addiction in a variety of ways. Some act out and express their anger in misdirected ways. Others shut down and become quietly fearful, anxiously anticipating the next "shoe to drop". Some children try to fix things and take control—sometimes by playing the responsible parent to their younger siblings. In many instances, the level of resiliency that children muster to cope with family dysfunction is striking.

Beyond the acute effects that parental addiction can have on children, scientific research studies have demonstrated that children living in such households are at higher risk of longer-term consequences, including, and perhaps ironically, addiction problems. Emotional and mental health problems, marital difficulties, and inadequate parenting in adulthood can be traced back to early traumatic experiences associated with living with a parent with addiction.

Possible Solutions: The Betty Ford Children's Program

Despite our knowledge of the acute and longer-term consequences of living with a parent who has an addiction to drugs and/or alcohol, services are scarce to help these young children understand and cope with their experiences. One such program is the Children's Program of the Betty Ford Center, designed more than two decades ago. This three- to four-day intensive day program enrolls children who are 7 to 12 years old. Through an engaging mixture of games and activities led by trained counseling staff, children are educated about the nature of addiction and how it can disrupt the lives of parents and other family members. One of the most important messages that the program tries to impart is that the children are not at fault for the chaos that is plaguing their family. The program provides ample opportunities for children to share their feelings and experiences in a safe and friendly environment in the presence of other children who are experiencing similar situations. Another important goal of the program is to teach children that recovery is possible if the person with the addiction seeks the right kind of help. To

date, it has served more than 23,931 children and family members in its three locations in the United States. An evaluation conducted in 2004 showed significant increases in child assertiveness and several other positive changes in child attitudes and knowledge immediately following the program.

Description of the Evaluation

This report describes the findings of the latest evaluation of the Betty Ford Center Children's Program. The evaluation was independently funded through a grant from the Conrad Hilton Foundation and conducted by researchers at the Treatment Research Institute (TRI) in Philadelphia, PA. TRI research staff worked closely with the staff of the three Children's Programs to recruit families for the evaluation. Participants were ensured that their identity and responses would be kept completely confidential and not shared with Betty Ford program staff. Although parental consent was necessary for children to participate, participation was completely voluntary. Children who assented to participate were informed that no one would tell their parents what they reported to research staff.

The evaluation built upon the initial one in three important ways. First, rather than measuring outcomes prior to and immediately following the program, participants in this evaluation were assessed both prior to and at least six months after completing the program. Second, rather than only collecting data from children who participated in the program, this evaluation collected data from both parents and children to gain an understanding of the possible impact of the program from both the child perspective and that of the caregiver/parent. Third, this evaluation measured additional domains of functioning that were not covered in the initial evaluation. For example, parents provided information using valid, standardized instruments on signs and symptoms in the child prior to and after completion of the program to evaluate the degree of change. Similarly, an instrument to assess general family functioning was administered at the two time points for comparison purposes. Finally, at the post-assessment (i.e., several months after attending the program), research interviewers asked parents and children using an open-ended format regarding what they liked and did not like about the program and what they remembered to be the most important things that they learned as a result of attending the program.

Data were collected from 140 parents and 103 children prior to program entry. Follow-up interviews were conducted with 114 parents and 75 children, representing an 84 and 73% follow-up rate, which is highly acceptable for research studies of this kind. The individuals who participated in the follow-up interviews were comparable to those who did not participate on sociodemographic characteristics, lending confidence to the representativeness of the follow-up sample relative to the baseline sample.

Results

The results of the evaluation showed a consistent and high level of satisfaction from both the child and parent perspective. Only two of the 114 parents expressed any kind of dissatisfaction with the program, with one offering a comment about how the program was “too intense” for her child. All other parents who participated in the follow-up had exceedingly positive things to share about what they liked about the program and how it benefitted their child. Many of the intended messages of the program were retained by a large number of the children, even months after completion of the program. Parent reports corroborated this finding, with many parents echoing the same responses of the children. For example, both parents and children remarked that one of the most important things that the children learned was that they were not to be blamed for their parents addiction. Another critical message retained among many was that the person with addiction should be separated from the addiction itself.

The qualitative findings were poignant and compelling evidence that the program had a lasting impression on the children. The children’s responses illustrated how they really enjoyed the more serious elements of the program in addition to the fun they had. Many commented on how the best thing about the program was getting to “express,” “explain,” and “share” feelings. One child said, “I liked getting it all out so I was not so uptight.” Another eloquently stated: “The fact that I could tell them without feeling guilty about how I felt about what happened and all the things that had gotten in my way.” Others said, “I got to explain about the troubles in my family” and “I liked how to better communicate with my parents and express my feelings.” One child said, “It was not as awkward as I thought it was going to be.”

One of the takeaway messages from the findings is that the more serious messages were retained because they were learned in a comfortable, fun, and safe atmosphere. As an illustration of how these two things are intertwined in a child’s mind, one child’s answer to the question about what they liked the most was “how they explained how alcoholism can hurt your family and how they served all the lunches.” Another said, “Swimming and learning was fun.”

It was clear from many of the responses from the children that they had gained not only an accurate view of the complex and chronic nature of addiction, but a compassionate one. Responses like “people are not bad but they may be doing bad things.” The following are some poignant statements that further illustrate their deep understanding:

“I learned why people relapse and that it’s not their fault.”
“That addiction can get you very quickly.”
“Don’t get stuck by addiction.”
“Addiction is really hard to get rid of but you can through help.”

Several quantitative comparisons were made to gauge changes in child knowledge and functioning from baseline to follow-up. Statistically significant increases were observed in the children's knowledge that treatment can help individuals with addiction. At baseline, 47% of children answered affirmatively to the statement "Treatment helps people with addiction" and at follow-up, that percentage increased significantly to 74%.

No statistically significant changes were observed on standardized measures of self-efficacy, but emotional self-efficacy scores appeared to increase relative to scores on social self-efficacy. With respect to school performance, a majority of the children were performing very well academically at baseline (86% reporting that they received mostly As and Bs in school), with little room for improvement at the group level at follow-up. Not surprisingly, given the high baseline levels, no significant changes were evident on this indicator at follow-up (89%). However, the percentage of children who reported that it "is very important to go to school" increased significantly from baseline to follow-up (86% to 95%). With respect to intention to use drugs or alcohol, at baseline, the vast majority of children reported no intention to use alcohol, marijuana, or tobacco (94%, 86%, and 94%, respectively). At follow-up, owing most likely to a "ceiling effect", these figures did not change significantly.

From the parent's perspective, several signs of improvement in child functioning were evident following the program as measured by two standardized instruments. Statistically significant reductions in behavioral and emotional problems were observed from baseline to follow-up. Moreover, statistically significant improvements were reported by parents on a standardized measure of family functioning.

Although additional analyses can and will be conducted to examine possible moderators and mechanisms of outcomes, these evaluation results provide strong evidence that the program was well-received by both parents and children. The significant decreases in parent reports of behavioral and emotional issues following completion of the program and the significant increase in family functioning are strong signals that the program had a beneficial impact on children. The evaluation demonstrated that most of the major messages imparted by the program to the children were retained even several months after the program ended.

Going Forward

The evaluation also sheds light on possible refinements and expansion opportunities for the program going forward. Given that a significant proportion of the sample studied reported symptoms indicative of possible depression and anxiety disorders, program staff could consider providing referrals for more comprehensive evaluation of mental health problems. Indeed, many of the parents mentioned that the children were already being seen by a professional therapist. Moreover, the results of the

evaluation demonstrated that only 17% reported contact with program staff after the program had ended, even though phone numbers and contact information had been provided to them. The high response rate achieved by this evaluation bodes well for maintaining contact in a more proactive manner by program staff. The successful implementation of the evaluation demonstrates the feasibility of evaluating the experiences of young children and their parents who attend the program. If additional resources were available, maintaining regular contact could serve the dual purpose of providing additional useful materials by email as well as allowing for even longer-term and more systematic evaluation of participants in the program.

Conclusions

The evaluation results demonstrate that the program as it is delivered currently successfully meets many of its intended goals. Both parents and children reported a very high degree of satisfaction with regard to several aspects of the program. First, they liked the way the program was run – that the days were filled with a mix of fun things to do as well as learning about serious topics. Children felt comfortable sharing difficult feelings and stories in small groups and felt respected by the staff. Ample opportunities were given to share feelings and experiences verbally, in writing and through art work. Many important messages of the program were imparted – that children are not alone, that the disease of addiction can be seen as something that is separate from the person who has addiction, that treatment and recovery not only exist, but that working in treatment to achieve recovery can be helpful. Most importantly, many children understood that they were not at fault for their parent’s addiction.

Probably most striking and most compelling findings of the evaluation was the comparison of standardized measures of behavioral and emotional functioning of the children collected from parents before and several months after the program. From the vantage point of the parents, significant improvements were seen with respect to these dimensions of child functioning. Moreover, similar gains were seen with regard to the measure used to assess family functioning as a whole.

Having a parent with addiction is widespread and few resources have been directed at mitigating the collateral damage on children who are affected by parental addiction. The results of this evaluation call attention not only to the positive nature of the Betty Ford Children’s Program, but to the need for expanded resources for the millions of children living with parents with addiction. Programs are needed that can expand on the Betty Ford Children’s Program model and perhaps address the high-risk developmental period of adolescence. With the caveat that longer-term attention to these children over their life course would be optimal, the Betty Ford Children’s program offers a hopeful first step in disrupting the multi-generational legacy of addiction.

The Multi-generational Nature of Addiction

Addiction to alcohol and other drugs is a major public health problem, affecting tens of millions of U.S. households every year. It is estimated that 8.3 million children under 18 years of age (12%) live with at least one parent who was dependent on or abused alcohol or an illicit drug. Alcohol and/or other drug use by a parent can undermine household stability and can affect their ability to be a good parent. Research studies with parents who are drug users consistently find a high degree of family conflict, emotional disengagement, more punitive forms of discipline, inconsistent limit-setting, and in general, poor quality of the parent-child relationship. These problems most likely stem from a combination of poor family management and inadequate parenting. Indeed, addiction is often at the core of why parents come to the attention of the child welfare system.

Not only do children with an addicted parent face safety threats because of parental inattention and inconsistent child supervision and safety, but they also face emotional difficulties due to parental absence and lack of stable role models. Children from alcohol- and drug-using families commonly have problems forming positive peer relationships and are more likely to affiliate with deviant peers and become involved in criminal activity. In short, being a young child of an addicted parent places the child at heightened risk for adversity. Children of drug-dependent parents have an elevated risk of problematic patterns of behavior, social and school problems, erratic school attendance, and more internalizing (e.g., depression) and externalizing (e.g., conduct problems) behaviors. Many studies have shown that children of parents with addiction are at higher risk for addiction themselves, for both biological and environmental reasons.

Unfortunately, the number of children who have a parent with addiction appears to be increasing, placing many children at risk for adversity. Although many scientific studies have demonstrated the benefits of addiction treatment (e.g., reduced drug use, improving family functioning), their children have rarely been the focus of direct interventions. Because of the multi-generational nature of addiction, intervening with children of parents with addiction represents an opportunity to interrupt the legacy of addiction. Surprisingly few programs exist in the United States that focus on children of parents with addiction. While adult treatment programs provide services for adults to promote their recovery, few focus on the needs of the children of their patients.

Since opening in 1982, the Betty Ford Center has provided addiction treatment services based upon the philosophy that (a) addiction to alcohol and other drugs is a family disease, and (b) success in maintaining a stable recovery program is enhanced when family members of the actual patient participate in the treatment process.

How to best address the emotional and psychological impact of being a child who has a parent with an addiction problem is a critical public health issue, one that the Betty Ford Center set out to address early in its history with the establishment of the Betty Ford Center Children's Program.

Although periodic children's programs took place from time to time, since the beginning of the center, the Betty Ford Children's program was formally established in 1996 and is currently functioning in three locations. The Children's Program is a multi-day, comprehensive preventive intervention program for children age 7 to 12 who have at least one parent, grandparent or older sibling with addiction. In some locations, it is offered as a four-day program at community sites or in local elementary schools. Originally available only to Betty Ford Center patients, the Children's Program in 1996 was expanded to include non-patient families at community sites throughout the Coachella Valley. Based upon requests from alumni to offer the Children's Program in other areas, the Betty Ford Center opened its first off-campus location in the Dallas-Fort Worth area in the fall of 1998. Since then, the DFW "Five Star Kids" Children's Program has served nearly seven thousand children and family members. In 2003, The Children's Program was expanded for a second time with the establishment of children's programs in Denver to serve Colorado and surrounding states. With deployment in three Betty Ford Center-sponsored locations, the Children's Program has now touched over 15,500 children and 9300 adults since 1998.

The large number of parents undergoing addiction treatment and the even larger pool of children affected by parental addiction underscores the need to design and implement preventive intervention strategies that lessen the impact of parental addiction on children. The evaluation of the Betty Ford Children's Program serves as a model for how to evaluate the effectiveness of such strategies, as well as raise national attention around the need to break the cycle of intergenerational transmission of familial addiction. The research can help strengthen our capacity to design new prevention strategies to build youth resiliency, enhance coping strategies of high-risk youth, and reduce adolescent substance use. Moreover, it is possible that new clinical practices can emanate from our work with children of addicted parents to enhance the quality of life of parents and families in long-term recovery.

Description of the Program

The Betty Ford Children's Program is a structured multi-day program (depending on location) for small groups of 7-12 year-old children who have a family member with addiction. The activities are led by trained counselors and allow plenty of opportunities for children to get to know one another through familiar fun activities (e.g., pool time, traditional games), as well as developmentally-appropriate activities geared toward

learning about addiction, treatment and recovery. The children are empowered to express themselves in a variety of ways that tap into different expressive styles (i.e., talking, writing stories, and creating art). Through structured group activities led by the counselor, they take turns sharing their feelings and experiences about living with an addicted family member or more generally, about their life as a child.

Early in the program, children learn about how people with addiction are holding on to a lot of negative feelings that have weighed them down throughout their life. In one activity, children are shown and asked to carry around a 41 pound “bag of rocks”. After experiencing kinesthetically how heavy the bag is, the contents of the bag are revealed. Inside are rocks colorfully painted with words like “shame”, “depression”, “anger”, and “hurt”. The counselor explains how people with addiction have had to carry the bag of rocks around a long time, even before they had children. In this way, the child begins to have a better understanding of addiction, and realize that they could not be the reason for the addicted person’s negative emotions and behaviors—that the stuffed up feelings inside the bag of rocks really is the culprit.

Another activity used to teach children about the separation between addiction and the person who is addicted involves role plays between a character “Addiction” (played by an adult group leader) and a “dependent” (played by a child). When Addiction the Disease sneaks up on the dependent and “traps” them, the dependent realizes how addiction can hold a person “hostage”. It is only when the character “Treatment and Recovery” (T&R) arrives, the arch nemesis of Addiction, that the dependent is freed. Several other activities are used to engage children in structured ways to elicit, describe and share feelings to others in the group. One example is the “Feeling Wheel”, where various feelings are written on a spinner and each child takes a turn spinning the wheel and describing the feeling. Through another activity, called the seven C’s, children learn a catchy way to remember that their family member’s addiction is beyond their control. They learn that they didn’t **C**ause it, that they can’t **C**ontrol it or **C**ure it, but that they can learn to take **C**are of themselves, by **C**ommunicating feelings, making healthy **C**hoices, and **C**elebrating themselves. Self-care is a major theme of the activities and children are taught how to find safe people and safe places.

The decision to design the program around 7-12 year olds was based on three reasons. First, the earliest age for starting to use alcohol and drugs is typically the middle school years, if a person begins at all. Focusing the program on younger children increased the chance that the children attending would not have started using and therefore the uniform prevention-oriented message of the program to all attendees could be “not to start using alcohol or other drugs”. Second, managing the behavior and emotions of children who were younger would present difficult challenges that might interfere with smooth functioning of the day’s activities. Children who are 7-12 years old are accustomed to being

away from their parents all day for school and are learning how to be independent with respect to basic skills. Third, 7-12 year old children are in a unique stage with respect to their cognitive development. Namely, they are likely to learn new concepts if they are presented in a concrete fashion. Many of the activities of the program have in common a high level of literal representation (e.g., the addiction “monster”, the superhero Treatment and Recovery - “T&R”, the “bag of rocks”).

On the last 2 days (except in Texas where it is the last day) of the program, parents are invited to join their child in the group activities and children will read letters to their parents in the presence of others about how they feel about addiction affecting their lives. Although this activity can be somewhat difficult for parents, they are usually impressed by their child’s honesty, their level of newfound understanding and the language they have learned to express their feelings. The final day involves a celebration for the children followed by a final meeting with parents/caregivers to review a continuing care plan and staff’s recommendations.

Description of the Evaluation

Overview: This report describes the systematic evaluation of the Betty Ford Children’s Program. Although an earlier evaluation of the program showed promise, it was conducted in only one site and was designed to measure immediate changes in children’s knowledge and attitudes after participating in the multi-day program. This evaluation involved all three sites, employed a rigorous and comprehensive assessment, and used a prospective design to collect data on children and their parents.

Sample: To be eligible for the evaluation, children were included if they were 7 to 12 years of age; new to the Children’s program; the only child in their family who ever attended the program, and did not have any severe mental or learning impairment that would preclude administration of informed consent or participation in interviews. Children of all racial groups were invited to participate, but to ensure a proper understanding of the interview procedures and content, family members had to be proficient in English.

Procedures: The evaluation was independently funded through a grant from the Conrad Hilton Foundation and conducted by researchers at the Treatment Research Institute (TRI) in Philadelphia, PA. TRI research staff worked closely with the staff of the three Children’s Programs in the three locations where the Children’s Program is currently operational (i.e., Dallas, TX, Denver, CO, and Rancho Mirage, CA) to recruit families for the evaluation. Program staff were requested to provide information about the evaluation to parents who inquired about enrolling their child in the program. Although attempts by program staff were made to involve as many parents as were willing, the final sample should be considered a convenience sample as opposed to a systematically drawn random

sample or random sample of consecutive admissions to the program during the evaluation period. In many cases, time constraints precluded research staff for making contact, administering informed consent and scheduling the baseline assessment on all parents that might have been interested in participating. Participants were ensured that their identity and responses would be kept completely confidential and not shared with Betty Ford program staff. Although parental consent was necessary for children to participate, participation was completely voluntary. Children who assented to participate were informed that no one would tell their parents what they reported to research staff.

Children and their parents/caregivers were enrolled consecutively into the study. Children were assessed at baseline using a child-friendly web-based survey tool that allowed children to listen to the questions being read to them to minimize any misunderstandings due to literacy issues. Parents were assessed via phone interview. At least six months later, follow-up assessments were administered to measure changes in personal, social and family functioning.

Goals of the Evaluation

The evaluation aimed to:

1) Describe the satisfaction with the program from both the child and parent perspectives and the degree to which key messages imparted by program activities were retained following participation in the program. This information was collected after participating in the program through interviewer-administered open-ended questions¹.

2) Document the degree to which changes occurred in youth participants following exposure to the Children's Program regarding: a) knowledge about addiction, treatment and recovery; b) quality of the parent-child relationship; c) academic functioning; d) self-efficacy, knowledge of where to find help and security in seeking out safe people; and e) risk of using alcohol, tobacco or marijuana if offered a future opportunity to use.

3) Describe the differences in the child's behavioral and emotional status that were reported by parents prior to and after program completion.

4) Describe changes in family functioning as reported by the parents prior to and after program completion.

¹ While the interviewers attempted to reflect as much of the responses verbatim in the database as was possible, responses were not recorded and transcribed word-for-word using any form of equipment. Therefore, the words noted in quotes throughout the following results section reflect the interviewer's record of the response written into the database.

Measures Used in the Evaluation

Child Assessment	Baseline (web)	Follow-up (web)
<i>Sociodemographics</i> Age, gender, race/ethnicity	✓	
<i>Program satisfaction</i> (Likes and dislikes)		✓
<i>Important things learned from participating in the program</i>		✓
<i>Mental health</i> Depression (Center for Epidemiologic Studies – Depression Scale) Anxiety (Anxiety subscale of the Baltimore How I Feel Scale)	✓	
<i>School functioning</i>	✓	✓
<i>Relationship quality</i> (With mom and dad separately)	✓	✓
<i>Knowledge of addiction and treatment</i>	✓	✓
<i>Ability to find a safe person</i>	✓	✓
<i>Self-efficacy</i> (Social and emotional)	✓	✓
<i>Likelihood of alcohol, tobacco and other drug use</i>	✓	✓
Parent Assessment	Baseline (phone)	Follow-up (phone)
<i>Sociodemographics</i> Relationship to the child, age, gender, marital status, race/ethnicity of respondent and child, educational attainment, employment status	✓	
<i>Reasons for accessing the program</i>	✓	
<i>Knowledge about the program</i>	✓	
<i>Program satisfaction</i> (Likes and dislikes)		✓
<i>Important things child learned from participating in the program</i>		✓
<i>Pediatric Symptom Checklist</i> (35 items)	✓	✓
<i>Strengths and Difficulties Questionnaire</i> Subscales: emotional symptoms, conduct problems, hyperactivity, peer problems, prosocial skills	✓	✓
<i>Family Assessment Device</i> (12 items) Support, functioning, decision-making	✓	✓

Results

Sample Characteristics and Follow-up Rates

Prior to program entry, data were collected on 140 parents and 103 children. The majority of the parents was the child's mother (66%), most were White (81%), married (55%), employed full- or part-time (64%), and had at least some college education (79%). Heretofore, we refer to the adult individual who participated in the evaluation as "parent", with full recognition that in some cases, this individual was not a biological parent but some other family member. Follow-up assessments were completed with 114 parents (representing an 81% follow-up rate) and 75 youth (representing a 73% follow-up rate), both of which are highly acceptable for a research study of this kind. Analyses comparing the demographic characteristics of individuals who completed a follow-up and those who did not showed no statistically significant differences, lending confidence to the representativeness of the follow-up sample relative to the baseline sample.

Parent's Knowledge about the Program

Most parents found out about the program through word of mouth from a family member or friend. A few parents mentioned that their child's therapist recommended the program and three parents mentioned that a court official had either recommended or mandated program participation. In all cases, they were encouraged to try the Betty Ford program because they had heard that the environment was child-friendly, safe and group-oriented. A few had heard that the program director was very good with children. Betty Ford's reputation was specifically mentioned by six parents—one said, "He needed a group he had confidence in." Another had gone through Betty Ford's family program and had respect for it: "I knew that Betty Ford was a reputable program."

Parent's Expectations about the Program

The parents involved in the evaluation fell into two broad categories. The first group wanted to "fix something that was broken." This group of parents had noticed signs that their child was affected by their parent's addiction, including "struggling with anxiety," "shame," "confusion," "anger," "abandonment, regressing a lot," and having emotional outbursts, like "crying a lot," or a were experiencing a mixture of behavioral issues: "She was edgy, distracted at school, she'd cry out of nowhere." Other parents noticed that their children were "shutting down." "He doesn't share a whole lot and I'd like to help him get everything off of his chest," one parent remarked. Parents were hoping to get some help, such as "to repair a damaged relationship, so he can trust me again." Another said, "I want him to feel better." Another said, "He needs an outlet to open up about his worries and concerns - he's guarded even with his counselor." "I noticed that throughout the process of her dad going to rehab and his addiction she was not saying much and speaking about it," said another.

The second group was different in that they had not really noticed overt problems yet in their child but wanted them to participate in the program as more of a preventive

measure. The following statements are examples of such sentiments: “I want him to be healthier as he grows up”; “I’m not sure how she’s been affected, but sure she has, seemed like a good idea”; and “The more his mom can do now, the better off he’ll be later.”

Among the specific things that both groups of parents reported that they wanted their children to learn, 31% said something related to what addiction is and what it does to families. Many wanted their children to not feel so alone—to learn that other kids had gone through what they have. One parent remarked, “I feel like knowing that other kids are going through the same problem will make him feel that he’s not weird and that he’s not the problem.” Several wanted their child to know how to cope with the situation of having a parent with an addiction. One parent said simply, “to help her heal,” and another said, “that it’s OK to seek help.”

Many parents hoped that the program could educate their children about the intergenerational nature of addiction. One parent said that she’d like to “increase awareness that [they are] at risk for addiction too, but that they don’t have to go down that road.” In other words, to “get the skills they need to not repeat their parent’s experience”. Breaking the cycle of addiction in their family was a high priority for many parents.

Sixteen parents said that they wanted the program to educate the child that the situation is not their fault. “I don’t want her to feel guilty for how her mom’s behavior has affected her, or have her think that there was anything that she could have done to prevent her mom’s addiction or cure it,” said one parent. Other parents said something regarding wanting their child not to “feel responsible” for their parents’ behavior.

Many parents said that they hoped the program would help their child better express their emotions, including insecurity, anger, and loneliness. One parent said “My daughter needs better tools to identify feelings, to express how she is feeling about her mom’s addiction and give her a new language to describe the experience.” Another wanted their child to have the “tools to be emotionally healthy.” Another described wanting “peace and understanding about her own feelings and her mom’s addiction.” Parents in recovery expressed that they were “terrified” or “felt guilty” about what they had done to their child and admitted that sending their child to the program was a way of partially relieving their guilt. A family member said that “the mom’s addiction affected her own parenting skills, and that was a hindrance to her child’s development—she did not have social, coping skills, so the child could not learn these things from her.”

A few parents noted that their child was old enough to understand what was going on – that “it was time” to get some help. One parent said, “He’s coming into his teen years and now is the time.” Another said, “We’re getting to a point where he is having to face the reality and I am inexperienced at how best to explain it to him.” One parent said that the child had been “asking a lot of questions” and hoped that the program could answer them. Another said, “I do not want her to be in the dark.”

Expressions of Inadequate Alternatives and Feeling Ill-equipped to Help Their Child

Some parents pointed out the inadequacy of alternatives. “I take him to Al-Anon meetings and he sits in the children’s room and he has questions about what do the steps mean and I don’t know how to explain it to him so I figured this would be a good place.” A similar sentiment came from another parent who remarked that “Al-Anon was over his head.” Parents felt ill-equipped to help and felt that “professionals can better explain things.” “I wanted to see if they could explain it to him in a way that he can understand. It’s hard for me to do that,” one parent said. Another remarked, “I can’t explain addiction as well as someone who was trained.”

Parents’ Views of How Addiction Affected Their Child

Parents were asked in an open-ended fashion how addiction might have affected their child. Mentioned frequently was the negative impact of parental absence. “Her father has been away a lot,” said one; another said, “Well, he used to tell her he’d be right back and he wouldn’t be back for days.” And with parental absence came unpredictability, lack of structure, and instability: “His dad has been in and out of his life.” Parents described the situation as “chaotic” and “just crazy” and reported “fear,” “worry,” “anxiety,” “shame,” problems with feeling safe, “moodiness,” “nightmares,” and “school performance problems” in their child. Children were experiencing issues with “emotional regulation,” “trust,” and “sadness.” One parent said, “She had become very isolated and very sensitive where she would cry over anything.” Another said, “He had no connection with his dad which made him feel sadness a lot.” Neglect and feelings of loneliness were often mentioned, as were being let down, disappointed, and “feeling inadequate from a lack of attention, lack of involvement.” One parent summed it up by saying, “She doesn’t give herself permission to be a kid.”

One coping mechanism that children used was to take on more adult-like responsibility to try and control the situation: “She’s learning how to settle down and be more adult, she’s taking on more responsibility for her little brother.” It could be argued that this response is a positive one, but it is important to realize that the average age of this sample was 10, and that developmentally, children in these situations might be missing out on the positive experiences of being a child and benefits of having the security of knowing that there are responsible adults in their lives. Another parent said, “It took away her childhood, had to grow quicker.” “He’s had trouble being an 8 year old, feels angry, confused, he doesn’t understand why his life is different,” said another parent.

Some expressed the situation as very serious saying things, such as “I think the better question is how has he not been affected?” or “In every way that you could possibly imagine.” Others described the “negative impact of all the family drama.”

Children’s Baseline Mental Health Status

Mental health status of the children was measured at baseline with two well-validated instruments to assess self-reported depression and anxiety symptoms. While an appropriate comparison group is not available for reference, it is safe to say that

approximately 10-20% of the children exhibited high levels of anxiety, worry, and sadness. For example, in the past week, 22% reported not being able to focus, 13% felt down and unhappy, 16% said they were more quiet than usual, and 22% felt like crying. With respect to anxiety symptoms, 21% had trouble sleeping during the past week, 14% worried that bad things might happen, and 24% said that they sometimes or most times felt suddenly very scared for no reason.

After the Program... What Children Liked

In response to the question “What did you like the most about the program?”, children’s responses were largely consistent with each other and centered around four major themes: a) the fun activities; b) the chance to interact with other children who were experiencing similar issues in their families; c) learning about the nature of addiction; and d) being able to express their feelings in a safe and comfortable atmosphere with people who were nice to them and treated them with respect. Four children out of the 75 said that could not really remember anything.

Many children remarked on how “fun” the games, activities and art were and many mentioned specific things that they remembered doing, like the “bag of rocks,” “the connection sessions,” “the movie,” “writing the letter to my parent,” “making the circle,” “the chair thing,” and the “anger game.” Swimming in the pool got high marks by many, especially being able to “throw an adult into the pool.”

The program provided much opportunity to meet new people, and only one child commented that she was a bit uncomfortable with that aspect of the program. Many children voiced their enthusiasm about how much they enjoyed getting to know new people and interacting with other kids. This aspect of the program enabled the children to know that they were not alone in having to deal with addiction in their family. Some illustrative remarks include: “I got to meet other kids with similar problems,” and “sharing the same things about ourselves and understanding what people have been through.” Interacting with other children helped some children to “understand that (they) are not the only one with the problem.”

The children’s responses illustrated how they really enjoyed the more serious elements of the program in addition to the fun they had. Among the things that they liked the most about the program, many mentioned the information they learned about the chronic nature of addiction, the effects it has on families, and the importance of treatment. One said that she liked “learning the names of all the treatments they do, and all the different treatments available like AA.”

Many commented on how the best thing about the program was getting to “express,” “explain,” and “share” feelings. One child said, “I liked getting it all out so I was not so uptight.” Another eloquently stated: “The fact that I could tell them without feeling guilty about how I felt about what happened and all the things that had gotten in my way.” Others said, “I got to explain about the troubles in my family” and “I liked how to better

communicate with my parents and express my feelings.” One child said, “It was not as awkward as I thought it was going to be.”

One of the important takeaway messages from the findings is that the more serious messages were retained because they were learned in a comfortable, fun, and safe atmosphere. As an illustration of how these two things are intertwined in a child’s mind, one child’s answer to the question about what they liked the most was “how they explained how alcoholism can hurt your family and how they served all the lunches.” Another said, “Swimming and learning was fun.”

Moreover, the instructors delivering the messages were people that the children seemed to adore and felt they could trust. Many children remarked about how the staff were “really nice”, “funny,” and “easy to talk to.” One child said “They made you feel comfortable talking to them as well as they made it fun.”

Other children remembered liking the fact that parents were involved. Some children said that they liked “When my parents got to sit in,” “Being with my dad,” and “Being able to talk to my mom.” Three children commented on more operational aspects of the program by saying “I liked that there wasn’t a lot of kids but there was a small group to share more, it seemed really well organized,” another said that he “liked that they got a lot of stuff done”, and the third said, “I liked that you could be there with other kids and not alone or with your family.”

Finally, several children mentioned the food as one of the best things about the program. Being able to make their own lunches and eat free food were among the good memories of the program along with the more serious experiences. Five children had a very short answer to the question about what they liked the most: “Everything.” One child said. “I couldn’t pick, but I think I would choose every detail about it.”

What Didn’t They Like?

Overwhelmingly, child participants at the follow-up interview reported a very high level of satisfaction with the program. In response to the question “What things did you like least about the program?” three-quarters of the children responded simple answers: “Nothing” or “I loved it.” One said “no negative side,” with another saying, “Actually nothing because I got to express my feelings to people.” Two did not like it “because it was too short and wished there were a few more days.” Only a few children reported feeling uncomfortable—for example, one child said he did not like it that he “had to share a lot of uncomfortable things,” and two said that they “did not like the questions that were asked.” Another child noted that when “the adults came in the room and asked what you talked about —when they came in there, I felt nervous.”

Of the remaining 21 who reported at least one thing they did not like, most described fairly innocuous issues. One child reported that they “did not like getting up early.” Two reported that they “did not like to write” or “fill out sheets.” The remaining eight children said “I don’t really know” or couldn’t remember what they did not like, with

one saying, "There was one activity that was really confusing; I don't remember what it was," and another saying, "I wanted to keep the blocks that I drew on, but couldn't." Two children remarked that they would have like it better if the parents could sit in more, with one saying, he "wanted to be with his dad." Finally, one child said they did not like "not knowing anyone," and another said, "I don't know... with the learning thing about it... it needs to have a game involved with it."

What Were the Most Important Things the Children Said They Learned?

It was clear from many of the responses from the children that they had gained not only an accurate view of the complex and chronic nature of addiction, but a compassionate one. Responses like "I learned that alcohol is disease and that it is not the person's fault," that "it is not his fault and the person is not a bad person," and "that people are not bad but they may be doing bad things." All illustrate an understanding of addiction gained from the messages imparted by the program, notably, an understanding far beyond that of many adults. The following are some poignant statements that further illustrate their deep understanding:

"I learned why people relapse and that it's not their fault."

"That addiction can get you very quickly."

"Don't get stuck by addiction."

"Addiction is really hard to get rid of but you can through help."

"I learned about addiction and that you should ask for help if you cannot get away from it. It IS a disease. That's all I can really remember."

Other children recalled the need to help individuals with addiction. "When people have a problem, we should help them get through it," one child said. Other children commented about the widespread nature of the damaging consequences of addiction: "Everything you do can affect your family, if you do drugs that will affect them." Another said, "If you have someone in your family that has a problem it can spoil things for the rest of the family." Moreover, some children described how they learned how to deal with situations pertaining to addiction and what to do to cope with situations.

Another major lesson that emerged from the responses was related to the children understanding that the family problems they were experiencing were not "their fault." One girl said that she learned "how it wasn't her fault when her dad drank and got mad at her." Another said, "My own job is to be a kid," and another said she learned "how to take care of herself instead of dad."

Many children described their newfound understanding of how to express their feelings, that it was okay "to tell certain people who are safe our feelings - that you should be open." One child said, "It is ok to cry and that Betty Ford would help them." Another said, "From the bag of rocks I learned that it's ok to be mad and stuff but sometimes you gotta let it go." Some children commented on how they learned to "not to be scared

anymore,” “to tell people how you feel,” and “that it is OK to say what you think.” Some children described learning new “people skills”: “how to make new friends,” “how to like people,” and “how not to judge people.”

Another topic often recalled by the children related to the risks of using drugs and alcohol, and “that they are bad” and “how they can affect your entire family.” Several children commented that the program imparted a strong message about not using drugs. One child responded, “I learned about addiction... that it’s not good for you.” Finally, some general words of wisdom came from three children who recalled what they had learned from the program:

“That some people’s problems are bigger than yours.”

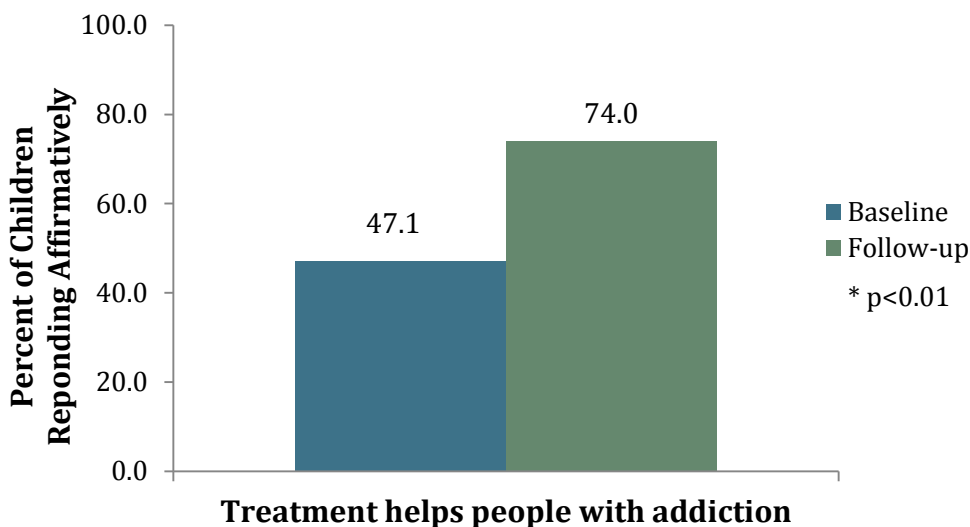
“To let time flow by itself and things will get better.”

“Don’t copy the bad things that our parents do.”

Children’s Knowledge about Addiction and Recovery

As seen below in Figure 2, significantly more youth at follow-up than at baseline reported that treatment can help people with addiction (47% vs. 74%). Children were also asked to respond to the statement “People with addiction are bad” with either a yes, sort of yes, no or sort of no response. The percentage who answered either “yes” or “sort of yes” decreased from 26.1% at baseline to 13.7% at follow-up but the difference was not statistically significantly different.

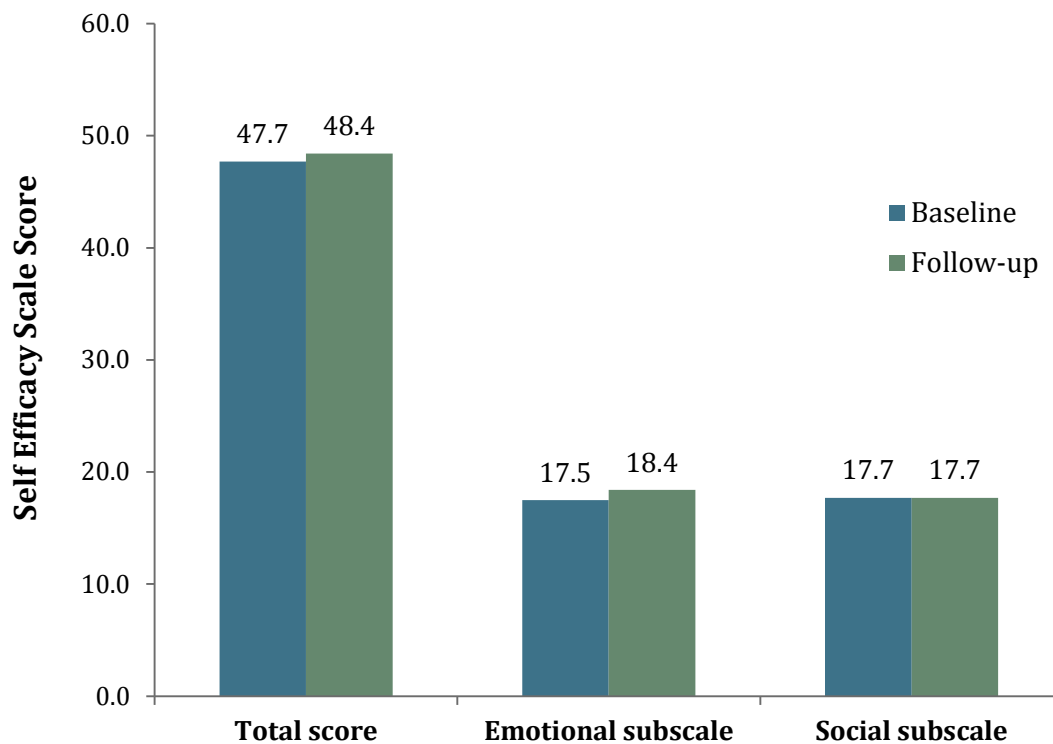
Figure 1. Increases in children’s perception of addiction treatment effectiveness following exposure to Betty Ford Children’s Program



School Performance

Children were asked at baseline and at follow-up about what they thought about going to school, experiences at school, and the grades they were receiving. In general, with a few exceptions, the children were doing very well academically at school. No significant differences were observed over the time period of the evaluation in the percentage of children who reported getting “mostly As or Bs”, but the percentage was high at baseline (86.5%) and was maintained at follow-up (89.2%). Notably, from baseline to follow-up, the percentage of children who reported that going to school was very important increased significantly from 86.5% to 94.7%.

Figure 2. Comparison of self-efficacy subscale scores as measured by the Self Efficacy Questionnaire for Children at baseline and follow-up.



Self-efficacy

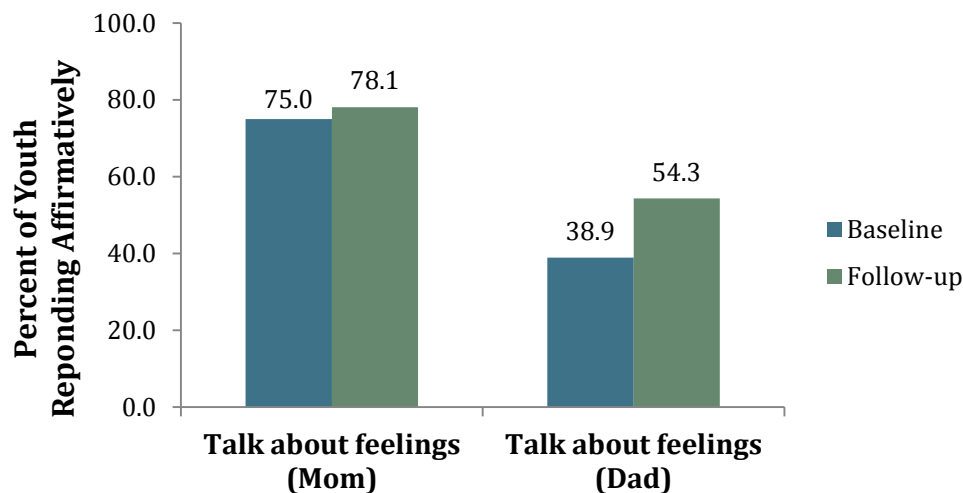
Self-efficacy in childhood is related to one’s self-confidence to accomplish goals and complete tasks. One of the important messages that the Children’s Program tries to impart is that it is possible to find safe people to express feelings to or to help if you are having a problem. At baseline and follow-up, self-efficacy was measured via a standardized instrument, the SEQ-12. Two subscale scores were derived from the instrument. The first, social self-efficacy, was comprised of items like “I am good at making friends with other children,” “I am good at cooperating with my classmates,” and “I can tell other children that they are doing something that I don’t like.” The second, emotional self-efficacy, is

comprised of items such as “I am good at expressing my opinions when classmates disagree with me,” “I am good at cheering myself up when bad things happen,” “I am good at calming myself down when I am very scared,” “I am good at keeping myself from becoming nervous,” and “I am good at keeping myself from worrying about the future.” No statistically significant changes in self-efficacy scores as measured by this scale were found between baseline and follow-up. There was a higher degree of improvement in emotional self-efficacy as compared to social self-efficacy, as shown above in Figure 2.

Parent-child Communication

Although more youth reported being able to talk with the parents about difficult feelings at follow-up than at baseline, these differences were not statistically significant (see Figure 3).

Figure 3. Children’s response to the question, “Can I talk about my feelings with my mom and dad?”



Child’s Self-reported Likelihood to Use Alcohol, Tobacco or Other Drugs

One of the major themes discussed during the Children’s Program is the risks of using alcohol and other drugs. Because the children involved in the evaluation are in their pre-teen years, the likelihood of substance use is very low, and thus, the measurement of risk for drug use focused on intention to use, rather than use. Children were asked three separate questions for alcohol, tobacco and marijuana: “How likely are you to try {substance} if someone offered it to you next summer?” At baseline, very few children reported any desire of trying any one of the three substances; 94.3% said they would definitely not try cigarettes, 85.7% said they would definitely not try marijuana, and 94.2% said they would definitely not try alcohol. At follow-up, no significant changes were noted in these figures, owing most likely to a “ceiling effect”—that the percentages were very high at baseline and there was little room for improvement.

From the Parent's Point of View: What Did the Children Gain from the Program?

When parents were asked open-ended questions regarding what they thought their children liked and did not like about the program and what were the most important things that their child got out of it, the responses were overwhelmingly positive. Many of the children discussed what they liked and what they had learned during the program with their parents. Only two of the 114 parents expressed any kind of dissatisfaction with the program, with one offering a comment about how the program was “too intense” for her child. All other parents who participated in the follow-up had exceedingly positive things to share about what they liked about the program and how it benefitted their child.

Some parents had very general remarks in response to the question, like:

“Everything about the program.”

“It was a positive experience for her.”

“She couldn't stop talking about it after.”

“She wanted to move in!”

“He wants to go back”

“She was excited and ready to go every morning, sad when it ended, wanted to keep going.”

Some parents commented on the developmental appropriateness of mixing fun (e.g., making lunches, swimming in the pool) with interactive activities and games that actually dealt with fairly serious topics. One parent said, “She liked the combination of playing and talking about problems.” Notably, many parents were able to rattle off the names of the games and activities even though more than six months had passed, like “Wheel of Fortune,” “grocery and ball,” “the bag of rocks,” “the exercise with the chair with group communication,” “the story about the bear in the trap,” and “the seven C's—that was really big for him.”

The themes that emerged from the parents' comments about the program echoed what was presented earlier in the report from the children's comments. In addition to many commenting about how their children became more “knowledgeable” about the damaging effects of addiction, parents described how their children liked understanding that addiction represented a set of behaviors and did not define the parent. “I think what he got from the program was the ability to separate the person with the addiction from his father” or “not that you're a bad person, but that everybody can do it, everybody makes mistakes and it affects other people as well.” Another said, “He learned that it was not his dad's choice,” and similarly another said, “He learned that it was his dad's disease that caused him to act this way.” One parent talked about forgiveness: “It was good for him to understand what was going on with his dad and it helped him kind of forgive him and forgive me and he said it helped him with his forgiveness.”

Several parents specifically stated that the most important thing learned was that the addiction was not the child's fault—for example, "That it wasn't his fault and he didn't do anything wrong." Another said that her child learned "That it was not her fault and that she could not have done anything to change things." Separating the addiction from the person—seeing the addiction as a "monster" that was affecting the parent's behavior—was clearly one of the key themes that emerged from the parent's responses. As one parent said, "We can separate the addiction we hate from the daddy we love." Another remarked, "We needed to decipher the difference between loving your father and the decisions he makes." Another parent described it as "Understanding that addiction has a face; that it is a separate individual and that Dad is a good person." One parent said, "She learned that addiction does not make you a terrible person and that it is more common than she thought." Another said, "She realizes that when you're dealing with an addict sometimes they can't prevent what they do."

Another theme emerged from the responses regarding the children's new knowledge that they could not shoulder the burden of their parent's addiction. One parent remarked that his child learned about the powerful nature of drug addiction and that the child "learned that he cannot make his loved one not do drugs." For one child who was playing the role of a parent to her younger siblings, the parent remarked, "She knows that she does not have to be a mom to her little sister anymore." Another said, "It has to be her mom that changes, not her." Yet another said, "It was that she was trying to be a parent to her father. She got out of it that she didn't have to be the parent."

Many parents mentioned something about the child having a better understanding of addiction as a disease as a result of participating in the program. Some parents felt that the children learned not only what addiction was, but that recovery was possible if the person with addiction asks for and gets the right kind of help and how going to meetings is an important part of recovery. Echoing what was learned from the children's responses, parents also commented on the children's new knowledge of the importance of treatment as a way of managing the chronic nature of addiction. One parent said that her child realized "how important it is to attend meetings even if it pulls them away from other things." Another said their child learned that "that there is no way out without getting help."

Similar to the children's own words, the parents echoed that the children liked being able to express feelings about their experiences and their thoughts about addiction and what was going on in their family. One parent remarked that he thought his child liked "that we finally brought the whole truth out on the table. I don't think we were hiding anything from them, but with their ages they needed some time." One parent remembered the message of the first day: "It is ok to cry and it is not your fault." "Sharing feelings" was mentioned by more than a dozen parents in response to the question. One parent said, "He got to tell dad things he wanted to tell him," and another said "He's comfortable, even though my husband still feels uncomfortable when he hears him talking that way."

Many parents commented on how the program taught the child to better express his/her feelings. One parent said, "She does not have to hold in her feelings, and that it's ok

to talk about her anger.” Being able to better express yourself has its advantages, as one parent remarked, “She’s better able to make her own choices.” The children also learned a new vocabulary for expressing feelings. One parent said she learned “the lingo; before she didn’t know what to call what her mother had, it gave her voice.” Another said the new terms learned provided “a common ground, a language that family could reference and build upon that simplified complicated things.” This same parent described the new words as “tools for the family.” Other parents said that the new language “gave a voice to things she wasn’t really aware of” or “my daughter was able to say that her parents were addicts.” Children learned that “speaking up,” “asking questions,” and “opening up,” even to the affected parent, is acceptable. As one parent said, “It is OK to talk to grandparents and counselors about her feelings, and she does not have to hide secrets.”

Many parents commented on what their child learned about the risks of drug use – “what types of things were harmful substances, what drugs are and which ones are addictive”—and that they now understand “why a person gets addicted” and how drugs can “interrupt your life.” The children also learned that in addition to affecting the individual, addiction can have more widespread radiating effects, especially on families. On a positive note, one parent remarked that their child learned about “the things that you can do to stay healthy and avoid addiction.”

Coping skills were mentioned as well: “He learned the tools to deal with the emotions that come along with someone with addiction” and “How to cope with it if she ever relapses again.” For children who are in the situation where a parent was still struggling with an active addiction, the program appeared to give the children new coping skills and a better understanding of what might be going on day-to-day. One parent said that the child understands now that “Mom is working to keep him safe not away from dad.” Another said that the child knows now to “talk to mom if he sees something his dad shouldn’t be doing.” Knowing that there are resources and people to help even after the program ended—in this regard, one parent remarked that “the Beamer books, paper with numbers to call, things to do to stay safe empowered her.” Another parent said, “If she ever has trouble there are other people that she can get help from.” “I would have to say how to cope with this issue more than anything else, and she and her sister have been in several situations where they had to make some tough decisions and stand up for themselves and protect themselves and this program did teach them something about that.”

A majority of parents also commented that one of the critical features of the program was “being able to interact with other children” and “hearing their stories.” The children found solace in knowing that they were not alone—that “other families are going through same or similar situations.” The children made new friends and felt “comfortable” with the other kids. One parent said, “I think she mentioned that one of the things she enjoyed was being able to be around other kids of the same age that were going through the same thing—that she’s not the only one going through this.” Another said, “He liked being with the other children and that he was not alone.”

The children reported back to their parents about the staff, who received high praises. Not one negative comment was received about the staff. Some recalled staff

members by name and talked about how the children “just adored the counselors” and “bonded” with them and that it was a good thing that they “were younger and fun.” From the comments, it was obvious that the children felt respected and “safe talking openly,” “special and important,” “wanted and loved,” and were “comfortable” and respected. For example, some parents said, “He liked getting attention,” “He was treated really good,” and “She was listened to.” One parent remarked that “the counselors were there to listen” and it was important to “just having someone acknowledge her feelings.” Another parent said, “The kids were important to the counselors.” One parent said, “He took a lot away from it and felt like he could express his feelings and he grew in his self-confidence when talking about his needs regarding his mom's addiction.” The Beamer character, books, and stuffed animals were mentioned by some parents as a nice element of the program. One parent commented on the process used to educate her child and said, “They were dealing with a serious issue in a way that made it seem more normal to him.”

Finally, as one parent said so eloquently, “The most important thing learned?... To be a kid.”

Changes in Child’s Emotional and Behavioral Problems

Parental reports of youth emotional and behavioral problems were measured with indicators of problems created with data from the Pediatric Symptom Checklist (PSC) and the Strengths and Difficulties Questionnaire (SDQ). The PSC consists of 35 items assessing a range of child emotional and behavioral problems that are rated as “Never,” “Sometimes,” or “Often” present and scored 0, 1, and 2, respectively. These items were summed to create an “impairment” indicator based on a score of 28 or greater. Sample items include “complains of aches and pains,” “spends more time alone,” “tires easily, has little energy,” “fidgety, unable to sit still,” “has trouble with teacher,” “is afraid of new situations,” “worries a lot,” and “does not show feelings.”

The SDQ is another measure of child emotional and behavioral problems and consists of 25 items assessing characteristics of the youth that are rated as “Not true” “Somewhat true,” or “Certainly true” and scored 1, 2, and 3, respectively. Sample items include “considerate of other people’s feelings,” “restless, overactive, cannot stay still for long,” “often complains of headaches, stomach-aches or sickness,” “shares readily with other youth,” and “often loses temper.” These items were summed (reversing scores when indicated) to create an “impairment” indicator based on a score of greater than 16.

Significantly fewer parents reported their children experiencing problems at follow-up than at baseline. As Figure 4 illustrates, significantly fewer parents reported their child experiencing impairment from emotional or behavior problems at follow-up based on the data collected with the PSC (35% vs. 15%) and on the SDQ (34% vs. 15%).

Figure 4. Decrease in parents' report of emotional and behavioral problems in children following exposure to the Betty Ford Children's Program

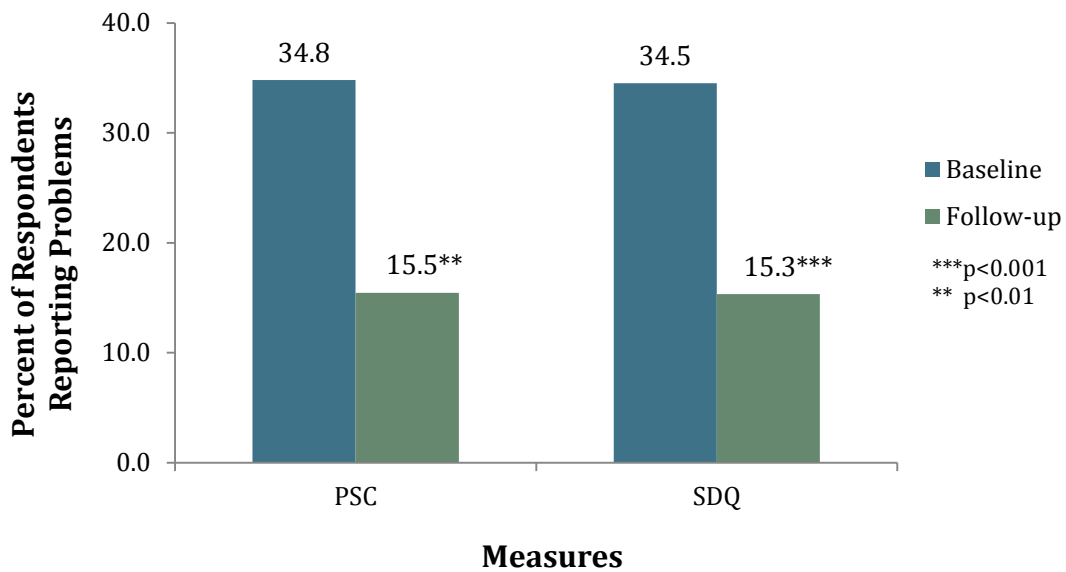
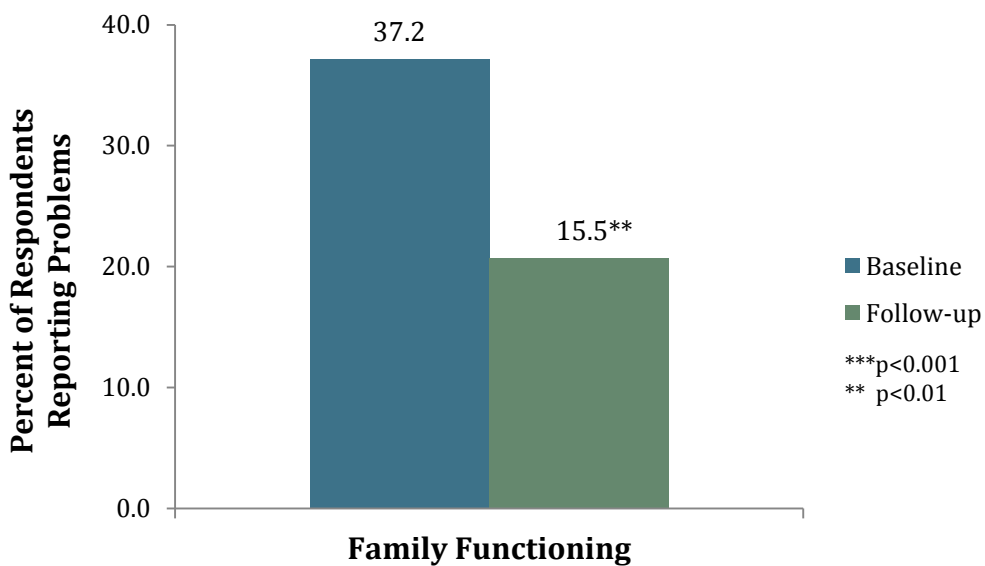


Figure 5: Improvement in family functioning as measured by parent responses to items on the Family Assessment Device following Betty Ford Children's Program



Changes in Family Functioning

Family functioning was measured using the Family Assessment Device. The FAD contains 12 items on general family functioning that are rated on a four-point scale from strongly agree to strongly disagree. Sample items include “planning family activities is difficult because we don’t understand each other,” “in times of crisis we can turn to each other for support,” “we cannot talk to each other about the sadness we feel,” “we are able to make decisions about how to solve problems,” and “we confide in each other.” Per scoring guidelines, items were summed and an indicator of family dysfunction was created to indicate an average score greater than 2. As shown above in Figure 5, significantly fewer parents (37% vs. 20%) reported familial dysfunction at follow-up as measured by the FAD.

In sum, analyses of outcomes using validated measures indicate a very strong sign from parental reports that child behavioral and emotional problems were less prevalent at follow-up than at baseline. Overall family functioning also improved at follow-up.

Conclusions

The evaluation results demonstrate that the program as it is delivered currently successfully meets many of its intended goals. Both parents and children reported a very high degree of satisfaction with regard to several aspects of the program. First, they liked the way the program was run – that the days were filled with a mix of fun things to do as well as learning about serious topics. The activities of the program were developmentally-appropriate and allowed for opportunities to share with other children their stories and experiences related to living with a parent with addiction. Ample opportunities were given to share feelings and experiences verbally, in writing and through art work.

Second, children reported that they felt comfortable sharing difficult feelings and stories in small groups and felt respected by the staff. One of the intended goals of the program is to make addiction more understandable and a little less scary to discuss. Some parents remarked that the program gave children a new language to understand what they were experiencing.

Third, many important messages of the program were imparted – that children are not alone, that the disease of addiction can be seen as something that is separate from the person who has addiction, that treatment and recovery not only exist, but that working in treatment to achieve recovery can be helpful. Most importantly, many children understood that they were not at fault for causing their parent’s addiction.

Probably most striking and most compelling findings of the evaluation was the comparison of standardized measures of behavioral and emotional functioning of the children collected from parents before and several months after the program. From the

vantage point of the parents, significant improvements were seen with respect to these dimensions of child functioning. Moreover, similar gains were seen with regard to the measure used to assess family functioning as a whole.

Having a parent with addiction is widespread and few resources have been directed at mitigating the collateral damage on children who are affected by parental addiction. The results of this evaluation call attention not only to the positive nature of the Betty Ford Children's Program, but to the need for expanded resources for the millions of children living with parents with addiction. Programs are needed that can expand on the Betty Ford Children's Program model and perhaps address the high-risk developmental period of adolescence. With the caveat that longer-term attention to these children over their life course would be optimal, the Betty Ford Children's program offers a hopeful first step in disrupting the multi-generational legacy of addiction.