Understanding the views of professionals of the impact of parental problem alcohol use on clients.

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Abstract

Background: Parental Problem Alcohol Use (PPAU) has been internationally acknowledged as an adverse childhood experience for at least two decades. It's wide ranging and often severe consequences on mental health throughout all stages of development have since been documented across various contexts. PPAU remains a highly prevalent issue in Ireland, affecting approximately 200,000 children and 400,000 adults (Silent Voices, 2019 . Alcohol Action Ireland, has published several documents with an aim to address this issue and advocate for the provision of services that can specifically deal with this topic. The aim of this project is to assess the current experience of working with adult and child clients who have grown up with Parental Problem Alcohol use across a wide range of mental health services, as well as the current preparedness for our services to deal with this issue.

Method: This is an explorative study utilising a purpose- built survey. This data includes a total of 132 survey responses to a 26-item questionnaire from a broad range of mental health professionals in Ireland. Qualitative responses are analysed using a mixture of thematic and content analysis. Quantitative analysis is primarily descriptive due to the exploratory nature of the study.

Results: The results demonstrate a significant need and want for an increase in training related to parental problem alcohol use within mental health sectors in Ireland. The risk and protective factors identified in this study highlight areas where interventions and programmes are most needed to reduce the impact of PPAU. Specific needs were found in relation to supports outside the family home that are accessible to children. These included a trauma-

informed and engaging educational environment that can connect children to counselling services, accessible social activities and relationship building initiatives.

Literature Review

According to the World health Organization (2018), alcohol is the cause of 3 million deaths per year globally. It accounts for 5.1% of global disease and 10% of all deaths in those aged 15 to 49, where it is the leading risk factor for premature mortality and disease (World Health Organization, 2018). Problem alcohol use is defined as exceeding the low-risk weekly limit of 17 standard drinks for a man and 11 standard drinks for a woman. One standard drink is equal to a small glass of wine, a half pint of beer, 35.5ml of spirits (HSE, 2019). Problem alcohol use has been well documented to affect physical health, psychological wellbeing and relationships (Mongan, 2007). For example, each year 1,000 people in Ireland are diagnosed with alcohol- related cancers. More than one in four emergency department visits are alcohol-related (HSE, 2019). People have an approximately 7 times increased risk for a suicide attempt soon after alcohol use, and a 37 times increased risk after heavy alcohol use (Borges et al., 2017). Parental problem alcohol use (PPAU) is solely concerned with a parent(s) alcohol use and the harms it causes to their children. More specifically, the effects it can have on the family as a whole, or on the child directly (Velleman & Templeton, 2007) by impacting on child welfare and child maltreatment (Cleaver et al., 1999). Research has indicated that adversity can be found even when the parental alcohol use does not meet the threshold of dependency (McGovern et al., 2018), the quantity of alcohol consumed is less significant than that of the pattern of use, the motivation for use and its consequences (Kroll, 2003).

PPAU is also commonly referred to as Parental Alcohol abuse/misuse. However, there have been a number of issues highlighted in regards to the utilisation of these terms. Kelly & Westerhoff (2010) found the term *substance abuser*, as opposed to *substance use disorder,* significantly more likely to be considered a personal choice. They also found it was associated with negative judgements and a need for a punitive rather than therapeutic response. After conducting a concept analysis on the term *substance misuse*, Mahmoud et al., (2017) found that it does not "accurately reflect the harms that may be associated with any substance use", and that the term lacks a precise definition. Kelly et al., (2016) stated that the absence of agreed-upon terminology can impede critical clinical information which may hinder an effective treatment plan and perpetuate stigma. While substance misuse captures the continuum of alcohol use, it implies a notion of choice, which contradicts with previous research exploring the role of genetics and environment in the aetiology of the illness (Wakeman, 2013) (Kelly et al., 2016) (Mahmoud et al., 2017). The reduction of stigma in this area is vital as it was cited as one of the main barriers to treatment (Substance Abuse and Mental Health Services Administration, 2008). Mahmoud et al., (2017) have instead suggested the term *at risk substance abuse*. Drugnet Ireland recommend rephrasing the term substance abuser as a *person with problematic substance use* (*Reducing stigma in Ireland*, 2018), therefore this paper will solely refer to it as parental problem alcohol use.

Parental problem alcohol use is often explored in conjunction with, and not as often as (Adamson & Templeton, 2012), Parental drug use in the international literature, where they are often termed together as Parental substance use (Horgan, 2011). However, important differences exist between the two. For example, unlike drugs, alcohol is legal, accessible and generally considered to be more socially acceptable. While this literature review draws from

a range of research covering both alcohol and drug use, the focus of this paper is solely on parental problem alcohol use.

It is estimated that 12.4% of the population are impacted by parental problem alcohol use in Ireland. This includes approximately 200,000 children who are currently growing up with PPAU, many of whom may experience this as a trauma, and 400,000 adults are the children of alcohol affected families. (Silent Voices, 2019). Over half of Irish adults with children living in their household reported regular hazardous drinking, translating to 271,000 children under the age of 15 (Hope, 2011). Another Irish study revealed that 9% of children reported that their parent's alcohol use affected them hugely in a negative way (ISPCC, 2010). Out of 5,762 people surveyed, The National Drug and Alcohol Survey 2019-20 revealed that the most reported harm from others drinking was harm that was caused to family (10.8%). However, this was the only type of data that this study collected in relation to how alcohol consumption may possibly affect children, as the study only collected data from 15+ year olds, and it did not ask respondents whether or not they had any children (Galvin et al., 2021).

PPAU has been classified as an Adverse Childhood experience (ACE) in the ten-item scale developed by Felletti et al., (2019). Numerous studies have suggested that exposure to cumulative ACEs may affect children's health and development in a number of ways, effects that often continue into their adult lives (Syed & Gilbert, 2019). It has been documented in the stories of adults who have experienced PPAU that it can have various effects on the atmosphere, communication, conversations, social life, rituals, routines, roles and celebrations in the family (Prior, 2020). For over two decades it has been acknowledged in

the literature that PPAU in the home is an "environment that is often perceived as threatening, hostile, non- nurturing and chaotic" (Thomas- Shepperd, 1995). PPAU also increases the risk for other ACE's, such as physical and emotional neglect, emotional, physical and sexual abuse, in addition to parental mental illness and divorce (Velleman & Templeton, 2007). One in ten parents who report regular hazardous drinking stated that their child experienced at least one harm as a result. These harms included verbal abuse, physical abuse, witness to violence in the home or being left in unsafe situations (Hope, 2011). One study found that in 38% of PPAU cases children had severe developmental needs and 57.1% had severe family and environmental difficulties, and that it is present in about one third of parental domestic abuse cases (Cleaver, 2008). It was outlined in the HSE's child welfare national reports that PPAU was present in one third of child abuse cases (AAI, 2022). Similar prevalence rates were reported over two decades ago, as Childline reported that one third of their calls were from children who identified their mother as having a drinking problem (Childline, 1997), thus indicating the stability in the prevalence of PPAU as an ACE.

PPAU is also associated with experiencing inconsistency from parent(s), feeling negative emotions such as "shame, guilt, anger and embarrassment", exposure to violence (Velleman & Templeton, 2007) and a higher risk of injury (Berent & Wojnar, 2021). Bijur (1992) explored the increased risk of injury children of problem drinkers were exposed to. After adjusting for race, family composition and mothers age, children of mothers classified as problem drinkers using the problem drinking scale, were at 2.1 times more risk to serious injury than children of mothers who did not drink, and were two thirds more likely to have serious injuries than children of mothers who drank moderately.

A consequence of the poor parenting practices that often co-occur with PPAU is the child adopting parenting roles (Burnett et al., 2006), known as Parentification, (Boszormenyi-nagy, 1981). Parentification is the reversal of a typical child- parent role as a result of a child attempting to atypically regulate their own needs for attention, comfort and guidance (Chase et al., 1998). Doing so may provide a sense of control in response to feeling frightened and helpless (Burnett et al., 2006) or a mechanism in which to regulate long-term stress (Tedgård et al., 2018). In cases of PPAU, instrumental parentification may take the form of filling the needs that parental problem alcohol use may prevent the parents from fulfilling, such as looking after themselves, other siblings, and the general household (Tedgård et al., 2018). Emotional parentification is when the child takes responsibility for the parents emotional needs. In the case of PPAU the child may buffer marital conflict, provide protection from violence and act as a friend or parent, rather than their child (Tedgård et al., 2018) (Templeton et al., 2009). These atypical levels of competencies in childhood was found to have significant consequences on mental health in adulthood, including feelings of emptiness, despair and anxiety which led to suicide attempts (Tedgård et al., 2018).

There are a wide range of psychosocial, academic, occupational problems that some adults experience as a result of experiencing PPAU. Studies indicate that those who have experienced PPAU are at an increased risk for developing depression (Anda et al., 2002; Klostermann et al., 2011). Anda et al., (2002) indicate depressive disorders are 30-50% more prevalent in adolescents compared to 3% of their peers who did not who experienced PPAU as an ACE. Klostermann et al., (2011) suggested that the experience of poorer family environment and parent-child relationships can cause those impacted by PPAU to develop less effective and more avoidant coping strategies. Anda et al., (2002) found that this

increased risk for depression is likely due to the exposure to other ACE's that often accompany PPAU, rather than the PPAU itself. Maternal problem alcohol has been shown to increase the risk for mental illness, drug abuse and suicide attempts in adulthood (Anda et al., 2002). The presence of PPAU can prevent secure attachments with parents in childhood (Murray, 1998), which has been shown to negatively influence relationships throughout adulthood and cause emotional issues such as shame, guilt, anger and frustration (Bickelhaupt et al., 2019).

Intergenerational problem alcohol use

Adults who grew up with PPAU experience an increased risk for PAU that can begin in early adulthood (Pearson et al., 2011). Although the majority of ACOA's do not have PAU, King & Chassin (2007) found this increased risk to be as much as doubled and Yoon et al (2013) found up to a 4-fold increase in risk which is highest when both parents have PAU. Dick et al., (2009) found that 50% of the variance of alcohol consumption can be accounted for by genes, which puts people who experienced PPAU at an increased risk due to their shared genes with their parent(s), which again is likely to be increased if both parents are problem drinkers. Warner et al (2007) found that people impacted by PPAU are at risk of drinking younger and experience a steeper escalation of alcohol use than children of non-alcoholic parents. This may be attributed to genetic and/or environmental, psychosocial and socio-economic factors (Ossola et al., 2021). Miller et al (1995) found an increased risk of externalising symptoms, such as developing an alcohol use disorder (AUD) (Ossola et al., 2021) in men more so than in women, who have been found to be more prone to internalising

symptoms (Hibbard, 1993). This suggests that gender differences may play a role in the development of an AUD in people who experience PPAU.

However, other factors are likely to play a part in this effect, including school performance (Gauffin, Vinnerljung & Hjern, 2015), maternal emotional closeness (Kelly et al., 2011). and exposure to binge drinking (Norway, Pedersen & von Soest, 2013). Specifically, studies suggest that children with poor school performance are at a higher risk for problem alcohol use in adulthood (Gauffin, Vinnerljung & Hjern, 2015). This is a common occurrence for children growing up with PPAU as they are more likely to attain lower academic outcomes (McGrath et al., 1999), have attention and conduct problems (Torvik et al., 2011), have inconsistent attendance and are more likely to drop out of school early (Berg et al., 2016). In a lagged longitudinal study, it was reported that girls with an emotionally close relationship with their mother drink less alcohol than those without. This indicates that emotional closeness and relationship quality between girls their mothers may buffer the risk of developing problem alcohol use. This effect was not found in boys (Kelly et al., 2011). In a longitudinal study carried out in Norway, Pedersen & von Soest (2013) found that binge drinking at age 28 was predicted by exposure to parental binge drinking during adolescence. Based on these findings, parental alcohol use is an important factor in the alcohol socialisation process.

However, it is difficult to determine the isolated effect that PPAU has on the risk of offspring developing problem alcohol use. This is due to the multitude of risk factors that can contribute to its development that are often co-occurring in cases of PPAU (Torvik et al., 2011). This is especially true in the clinical studies that, although are more vigorous than

population based samples using self-report measures, are typically made up of the most severe cases with participants also experiencing co-morbid psychiatric problems (Ohannessian et al., 2004). Nonetheless it is evident that people who experience PPAU are at an increased risk for problem alcohol use and alcohol use disorders.

Risk and Protective Factors

The effect that PPAU can have on parental and environmental factors as well as its prevalence with ACE'S and other risk factors can vary (Cleaver, 2008). If two or more risk factors, or ACE's are experienced together then the severity of consequences are compounded, and risk of harm increases (Anda et al., 2002) Rutters (1979) points out that it is not just about risks, it is also about the individual child, their context and their development, all of which may exacerbate, or lesson the effects of the risk(s) they may deal with together, separately or at different stages. Thus, the effects of PPAU are likely to be varied, complex in nature and dependant on a multitude of factors. One good adult is the largest protective factor for those impacted by PPAU (Silent Voices, 2020)

Toxic Trio

The notion of a toxic trio, or the rephrasing of it by the Association of Directors of Children's Services (ADCS) as the trigger trio, has been used in the past two decades internationally and more specifically in the UK, to refer to a cluster of risk factors that are seen to be particularly harmful to children's welfare (ADCS, 2021). Those being, parental alcohol and/or drug use, parental mental illness and/or learning disability, and domestic violence, all of which, are more likely to exist together than separately, and when they do occur simultaneously they are proposed to cause more risk than if they occurred on their own (Brandon, M. 2008). Either

separately or together, in 2021 the ADCS reported they are present in most of the cases that come into contact with early care and/or children's social care services (ADCS, 2021).

Socioeconomic status

PPAU exists across all social classes, however it is not clear if there are any difference found in its prevalence or effects across groups. There are relatively few studies which explore the relationship in non-clinical populations. A recent Nordic study by Haugland & Elgá, (2021) found that PPAU is more prevalent among those who have lower levels of education, lower economic status, who are on sick leave and who receive welfare- benefits. The Family Stress model (Conger & Conger, 2002) highlights a mechanism for how socioeconomic factors can lead to PPAU and the intergenerational continuity of alcohol use. They highlight the close link between three variables that can also play a large role in the outcome of problematic adolescent behaviours. Those being, family climate (overall family functioning), problem parental behaviours and financial hardship. It proposes that the latter can increase parental stressors that may possibly result in problem behaviours such as problem alcohol use, which may further interfere with family climate and dispose an adolescent to problematic behaviours, such as problem alcohol use themselves(Johnson et al., 2019). It shows a potential framework for how PPAU can be caused by socioeconomic factors but also moderated, buffered and prevented by them, such as supportive relationship between parents which can foster self-esteem and self-worth and effective problem solving, when stressors do exist within the family.

These findings indicate a higher prevalence of PPAU and socioeconomically disadvantaged groups. However, The Irish National Drug and Alcohol survey found that drug use is equally prevalent in low and high socioeconomic status groups. They did not, however, compare SES

groups in relation to problem alcohol use and/or PPAU (Mongan et al., 2022). Bosque-Prous et al., (2017) results indicated an importance of the adolescents own experienced SES rather than their parents.

Maternal and Paternal Problem Alcohol Use

Findings that maternal problem alcohol use is more harmful than paternal problem alcohol use are consistent across the literature (Anda et al., 2002; Rognmo et al., 2012;). One possible explanation for this is that mothers are the primary caregiver and bear the majority of the household responsibilities (Kuntsche et al., 2011). Templeton et al., (2009) suggested there are more men than women who no longer live with their children at the time of access to treatment for problem alcohol use, indicating an underlying explanation for the gender differenced often reported in clinical samples. One study found that children who had mothers who were problem drinkers, had a 48.9% chance of also having a father who was a moderate to heavy drinker. They found children had a signifigantly less chance (13%) of having a mother who was a moderate to heavy drinker when it was their father who was a problem drinker (Bijur, 1992). This indicates that when maternal problem alcohol use is present, it is more likely that both parents will have problem alcohol use. This has been shown to be more harmful than if just one parent had problem alcohol use (Thompson et al., 2016) (Moser & Jacob, 1997) (Anda et al., 2002). Some studies, however, report findings that contradict with maternal alcohol use causing more harm than paternal alcohol use and found no differences between the genders in how it disposes offspring to increased alcohol use (Pedersen & von Soest, 2013) (Coffelt et al., 2006) . Moser & Jacob (1997) found the presence of parental problem alcohol use did not impact on family positivity. Thompson et al., (2016) found maternal and paternal problem alcohol use equally increased the risk for

offspring lifetime suicide attempt. Several studies do not distinguish between maternal and parental problem alcohol use. These studies tend to find internalising symptoms in offspring rather than externalising symptoms (Rognmo et al., 2012) (Pisinger et al., 2016), which are more commonly associated with maternal problem alcohol use (Corte & Becherer, 2007). This may indicate that the effects found in non- gender specific PPAU are more commonly the result of maternal problem alcohol use. The most recent studies that explore the effects of maternal problem alcohol focus specifically on adverse foetal outcomes (Ciciolla et al., 2021; (Popova et al., 2021; (Addila et al., 2021), therefore more up to date explorations of gender differences are needed.

Protective Factors

Protective factors have been identified which can buffer the risks that can emerge in adulthood as a result of the exposure to PPAU, and also the co-occurring risk factors that often accompany it. They can be individual, familial and community- based (Velleman & Templeton, 2018). They often work by building the child's resilience which can improve the lifelong outcomes of their adverse experiences. Resilience has been defined as 'the capacity to adapt to and overcome stress and adversity' (APA, 2014). Children have been found to develop protective behavioural patterns that also act as tools for escapism (Keating, 2021). For example, coping mechanisms such as 'industriousness', where the child may use school as a safe haven, plunging themselves into their schoolwork, or "keeping busy externally to distract from inner turmoil" by engaging in extracurricular activities in order to minimise time spent at home (AAI, 2020).

Supports

While PPAU has long been recognised as a prevalent adverse childhood experience causing a range of difficulties for children and adults, there are no targeted and distinct services available in Ireland specifically equipped to deal with this issue (Silent Voices, 2021). There are also many factors that can prevent a child growing up with PPAU from accessing any services that may be available to them, such as contacting Childline themselves for support or highlighting themselves to those, such as teachers or neighbours, who may connect them with social care services. “Loyalty, secrecy and denial” often prevent potential services from accessing children who are growing up with PPAU, and it is often not expressed until the child is already outside of that environment (Taylor & Kroll, 2004). A UK based 2021 review documented barriers to accessing services that were reported by teenagers living with PPAU in descending order of significance. These included having a “Lack of confidence, lack of personal direction”, fear of “parents finding out, feeling comfortable enough or at ease with someone to tell them”, being worried about a brother or sister, not wanting school friend or acquaintances to know, having a “fear of it going further, for example to the police”. Furthermore, Harwin and Forrester (2002) found that early intervention is more common in drug use cases than in alcohol use cases, and intervention in cases of PPAU is less likely to result in the removal of the child in statutory child welfare assessments. Due to a delay in intervention, children were more likely to be exposed to, prolonged adversity and in some cases, very severe parental violence. They found that services were overall significantly ill-equipped to deal with the often complex cases presented by children affected by PPAU, and that an increase of expertise is required that adopts a sufficiently organized inter-agency approach. This is supported by another study which found that addiction services don’t focus beyond the parents alcohol use, and they do not, or are unable to support children who may be affected. When services are available to children, they are not always available to deal

with the wide range of therapeutical and practical support they need, and are often only available for a limited amount of time (Turning Point, 2006). Anda et al., (2002) found that the he prevention and treatment of PPAU related issues will depend on an active enquiry from mental health professionals.

Silent Voices Ireland (2019) have called on government to fund and incentivise trauma informed, innovative-evidence based services for children, families and adults affected by PPAU , provide educators with specific training on ACE's and information on PPAU to parents, health professionals, media, policy makers, volunteers and all those who may be in contact with children.

Due to the often hidden nature of PPAU, schools are vital when it comes to improving the lives of children affected by it, as this is where children spend most of their time outside of the home. Emotional/behavioural issues may emerge and school are well placed to identify children and families who may need support. The Irish National Teachers Organisation (INTO) have carried out a number of training programmes on adverse childhood experiences, including PPAU. 'Operation Encompass' is a UK based initiative which enables direct service support to children who are exposed to police attended incidents of domestic violence. It works by directly linking the police with schools in order to ensure rapid services are delivered to children who are impacted by domestic violence, and potentially PPAU as well (Operation Encompass, 2022). Silent Voices is currently advocating for this to be implemented in Ireland. They are also advocating for the supervisors in the HSE's new Crisis Text Line to be trained in issues surrounding PPAU (AAI, 2020).

When teachers are able to recognize ACE's in children, made possible by initiatives such as Operation Encompass and trauma-informed training, schools can become gateways to services that can help build resilience and coping strategies in children who are affected

(Doyle, 2021). When children access these services it is vital that the professionals are trained in issues related to PPAU so that they are adequately equipped at understanding and treating their specific experiences and adversities (Turning Point, 2006). In particular, psychotherapy, mindfulness and compassion focused therapy have been found to be particularly helpful for this population (Baird & Whelan, 2020).

Methods

This study was conducted in collaboration with Silent Voices, an initiative of Alcohol Action Ireland whose aim is to increase the level of services available for those affected by parental problem alcohol use (PPAU). This study used data from 132 survey responses to 26 questions in order to determine the experience that mental health professionals currently have in relation to working with clients who have experienced PPAU. It aimed to explore the level of knowledge, experience of and interest in the topic within MH professionals.

Participants

Participant recruitment

Participants were recruited through purposive sampling. an email which included an information letter (See Appendix 1) explaining the nature of the study and ethical considerations along with a link to the survey was sent to professional bodies representing mental health professionals (for example the Psychological Society of Ireland (PSI),The Irish Nurses and Midwives association (INMO). A request was made to facilitate the distribution of the research project details to members. Emails were also sent directly to public, private and community based mental health services across Ireland who deal with a wide range of

mental health issues. The survey was also shared on social media websites such as Twitter and LinkedIn.

Ethics

Full Ethical approval was obtained from the School of Applied Psychology Research ethics committee before the survey was distributed. Participants were briefed through the provision of an information sheet (See Appendix 2) and a consent form (See Appendix 3).They were informed that completion of the study is completely voluntary and that they are free to withdraw from the study up until submission. They were informed that due to the anonymous nature of this study it will not be possible to delete their data once their responses are submitted. Participants were informed prior to completion of the study that their anonymised data will be stored for at least ten years in UCC's data repository which will only be accessible to those who were involved in the project and that their data will be available to future researchers only after authorisation has been granted. Their anonymity was ensured by omitting any data that was identifiable, and IP addresses were not collected. Participants were debriefed by Thanking them for their participation and were also informed of services available to them if they are to experience any distress as a result of completing the survey..

Sampling Method

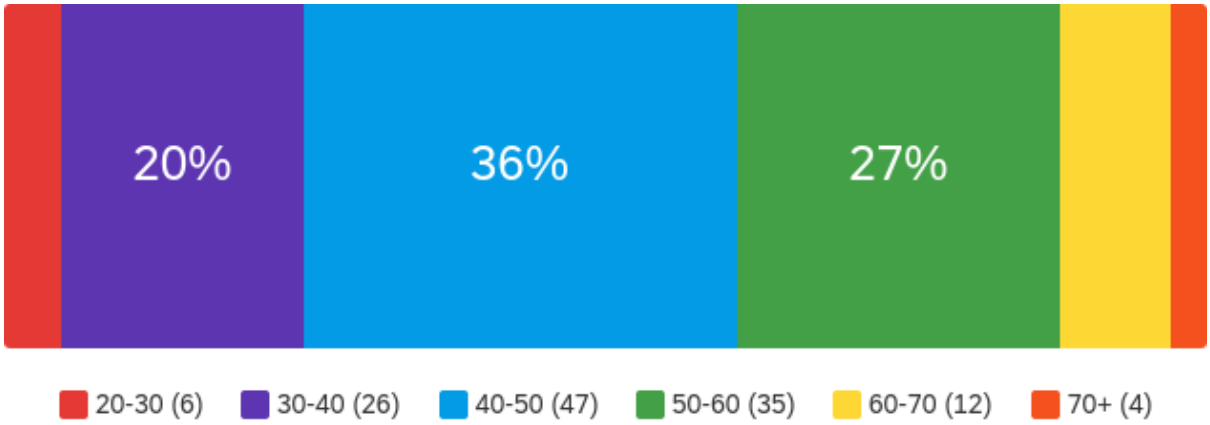
This study utilised a non-probability sampling method with a combination of convenience, voluntary- response, snowball and purposive sampling methods. Participants were self-selected.

Sample Characteristics

There were a total of 132 participants in this study, 98 of whom were females and 27 males, 1 non- binary and 6 who preferred to not say. 6 Participants were aged between 20-30, 26 between 30-40, 47 between 40-50, 35 between 50-60, 12 between 60-70 and 4 were aged 70+. All of the participants interviewed were mental health professionals, who besides for 9, had at least 2 years' experience. 59.09% of participants worked with adults, 4.55% with children and 36.36% with both adults and children. Professionals included those working as clinical(12), counselling(9), educational (2), chartered (1) psychologists, psychiatrists(2), psychiatric nurses(2), psychotherapists(27), counsellors(9), addiction counsellors(17), cognitive behavioural therapists(12), mental health social workers(3), mental health nurses(15), vocational supports trainers (2) and other (46). "Other" occupations included Addiction workers (9), project workers (5) general nurses (4), mental health support workers (3), paediatric nurses (2), general practitioner, intellectual disability nurse, adult safeguarding nurse, mediator family support, community and family support workers, youth mental health promotion co-ordinator, community development manager, fostering support worker, lecturer, social care manager, student social worker, public health worker and a clinical midwife specialist.

Figure 1

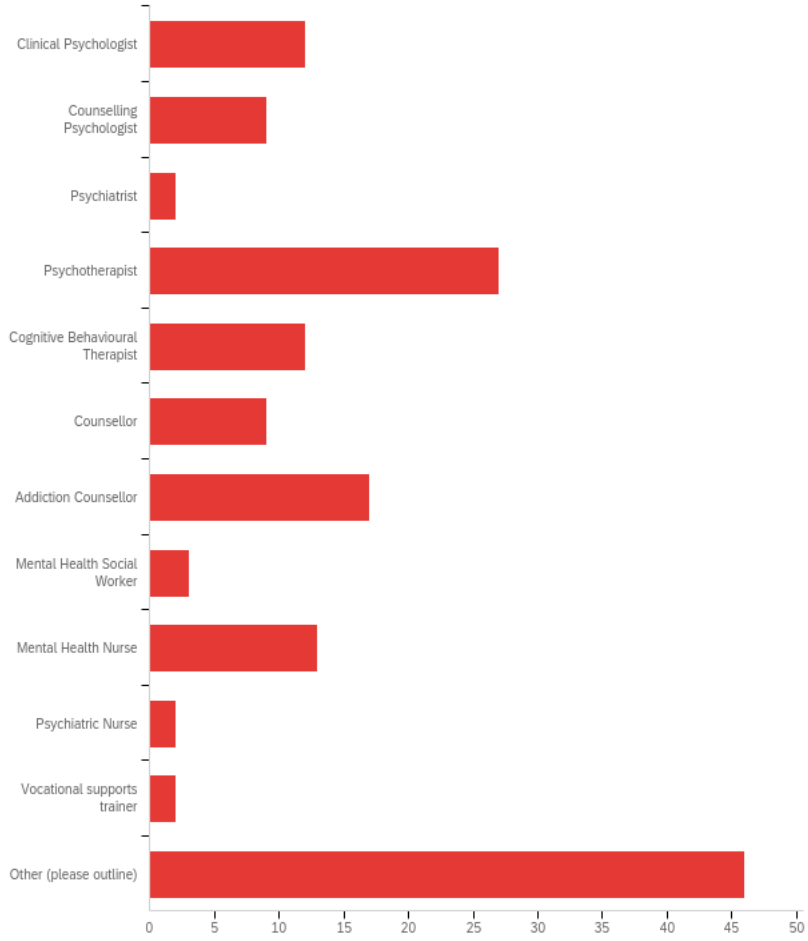
The Distribution of Participants across Age Ranges



Note. The bar chart illustrates the amount of participants in each age range. The line underneath shows what colour each group is referring to, as well as how many participants it consisted of.

Figure 2

The Distribution of participants across Mental Health Occupations

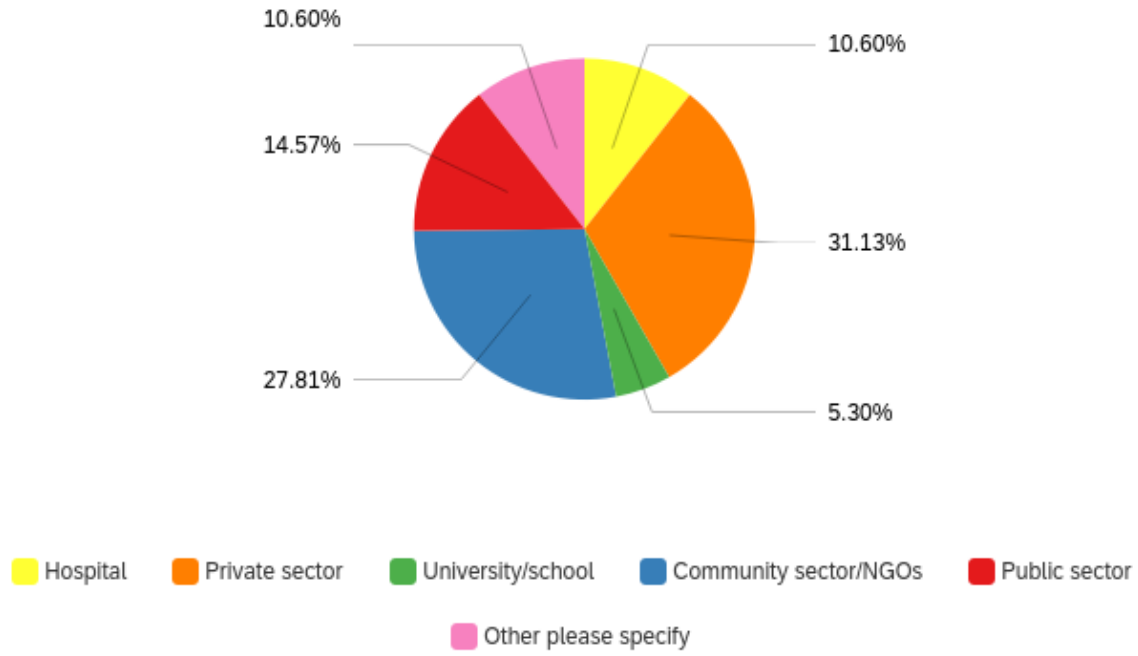


Note. This figure illustrates the amount of participants in each mental health occupation who completed the survey. The number of participants can be seen along the x-axis and the occupation type can be seen along the y-axis.

Participants worked across a broad range of settings including the private sector (N=48), the public sector (N=23), hospitals (N=16), community sector/NGO's (N=44), charity organizations (5), universities/schools (N=8), addiction clinics (N=3) and other (N=3). Other included phone support services, disability services and mediator family support services. 90.16% (N=110) of participants were based in Ireland, with the remainder working in the UK (N=12).

Figure 3

The Distribution of participants across Mental Health Settings



Note. This pie chart illustrates the percentages of each setting the participants worked in.

Materials

The purpose- built survey was designed through formulating questions based on a literature review conducted using UCC's library and Google Scholar. The survey was sent to Alcohol Action Ireland and Silent Voices for feedback and comments. The suggested edits were discussed and some were included. The survey was constructed and distributed in Qualtrics. The survey collected both demographics and open ended questions, the qualitative data was analysed using content analysis (Hsieh & Shannon, 2005), and thematic analysis using Braun & Clarke's (2006) six phase method for Question 18. Content analysis was utilised as it is a flexible approach that is suitable for short data responses. This was suitable for the data collected in this study which mostly consisted of lists. It also allowed for a quantification of

points that were made by participants, enabling an understanding of each categories frequency and therefore significance. Thematic analysis was utilised for question 18 in order to reveal the reoccurring patterns in the responses which tended to be more in depth.

Procedure

A literature review was conducted using UCC's online library databases and Google Scholar. The various terms often used to describe PPAU were searched including "Parental Alcohol Misuse", "Parental Substance Abuse", along with key terms such as "Ireland", "ACE's", "risk factors", "the effects in childhood and adulthood", "training in Irish services", "prevalence" and "protective factors". Government websites and documents were used as a key source of up to date information about PPAU in an Irish context, along with Alcohol Action Ireland's website and their Silent Voices Initiative related documents. The survey questions were drafted and shared between the research team and Alcohol Action Ireland/ Silent Voices personnel. Once their feedback was received and discussed, questions were modified accordingly. Ethical approval was sought from the School of Applied Psychology Research ethics committee. Once approval was granted the survey was constructed using Qualtrics.

Qualitative Analysis

Responses to the qualitative questions were read and re-read to ensure familiarity with their content. Responses that did not answer the question including "no", "not sure" and "I don't know" were discarded from the analysis. The remaining responses to the qualitative questions, excluding question 18, were analysed using content analysis (Hsieh & Shannon, 2005). For the content analysis, each point made by the participant was coded. If the response

did not answer the question then they were not coded. For example, if the question asked for a co-occurring risk factor and the participant mentioned consequences of growing up with PPAU in adulthood, then they were omitted from that questions analysis. Risk and protective factors were guided by the literature, roughly three resources for each qualitative question. If the risk / protective factors were not found in any of these resources then they were not included. The data was coded through the reduction to a word or 2- worded phrase. After each point was coded, the codes were grouped together according to their similarities and categories of codes were able to emerge. The amount of codes in each category were counted and displayed in descending order of frequency in a table. The codes were displayed in the graph to allow transparency into what went into each category. Risk factors were guided by three resources which demonstrate factors that increase a child risk for developing mental, emotional and behavioural issues in childhood and throughout development (National Research Council and Institute of Medicine, 2009; Essex et al., 2006; (Copeland et al., 2009). Protective factors were guided by three resources which outline factors that can buffer the effects of adverse childhood experiences on mental, emotional and behavioural development and health (National Research Council and Institute of Medicine, 2009; (Bachler et al., 2018; (Child Welfare Information Gateway, n.d.).

Question 18 was analysed using thematic analysis (Braun & Clarke, 2006) . The responses were read and re-read to ensure familiarity with their content and general notes were made about their content. Each point made in the responses was coded according to their meaning. Then the codes were grouped into themes. Each theme represented different approaches the mental health professionals had in regards to asking their clients if they had experienced PPAU. Then the raw data and codes were reanalysed to make sure they were appropriately

falling under each theme. The themes were then sharply defined and named in a manner in which they were self-explanatory. Then data extracts were selected that embodied the general theme and the various codes within it for the purpose of the write up of the analysis. The themes were outlined in a graph along with how many participants contributed to them.

Quantitative Analysis

Qualtrics was used to analyse the quantitative data. Significant findings were reported in the results.

Results

This study explored the awareness, attitudes, knowledge and training that a broad range of mental health (MH) professionals have in relation to working with clients who have experienced Parental Problem Alcohol Use (PPAU). It was an explorative purpose- built survey to which there were 132 responses, including 98 females, 27 males, 1 non-binary and 6 other. Participants worked in various sectors including private (48), NGO's (44), public (23), hospitals (16), Charities (5), Universities (8) and Addiciton clinics (3) and other (3). The results from the analysis using qualtrics, thematic analysis and content analysis will now be discussed.

The time participants have been in their current role varied from 4 months to 38 years. 2 participants were in their current role less than a year, 29 between 1-5 years, 29 between 5-10 years, 29 between 10-15 years, 28 between 15- 25 years and 15 participants were in their role 25+ years.

Table 1

Distribution of participants across number of years spent in role

Number of years in role	Number of participants	% of Participants
<1	*2*	1.52%
1-5	*29*	21.97%
5-10	*29*	21.97%
10-15	*29*	21.97%
15-25	*28*	21.21%
25+	*15*	11.36%

Note. This table outlines how many participants fell into each category of years spent in role. The middle column outlines the percentage of participants in each year group and the right column how many participants this refers to.

Training for Parental Problem Alcohol Use

70.16% (N=87) of MH professionals reported that they had not received any PPAU specific training. The occupations which had the least amount of professionals reporting they are trained in PPAU were psychiatrists (N=2), psychiatric nurses (N=2) and vocational support trainers [1](N=2).. Furthermore, only 2 out of 12 Clinical Psychologists, 1 out of 10 Cognitive behavioural therapists, 3 out of 11 mental health nurses and 3 out of 8 counsellors had received training specific to PPAU.

29.84% (N= 37) of participants reported they had received PPAU specific training.

[1] Vocational Support trainers help those with mental health problems find and maintain suitable employment (SOLAS, 2007).

The occupations which had the highest amount of professionals reporting that they are trained in PPAU were mental health social workers (66.67%, N=2) , addiction counsellors (57.14%, N=8), counselling psychologists (44.44%, N=4), and psychotherapists (40.74%, N=11). However, when asked to indicate what training was received, only approx. half of the professionals who reported that they received PPAU specific training, actually named a PPAU specific training. These findings demonstrate therapeutically orientated professionals have higher levels of PPAU training than clinically focused professionals. This is surprising given the high prevalence of PPAU in cases of moderate to severe mental health issues that clinically focused professionals specialise in treating. Such results indicate the distribution of PPAU training across mental health professionals is not proportionate to its need by service users.

92.11% (N=82) of participants reported that they would be supportive of all MH professionals being trained to a minimum degree to identify children who experience PPAU. 50% of clinical psychologists said they would not be supportive, followed by 1/6 psychotherapist, 2/7 Cognitive behavioural therapists and 1/5 counsellors. A limitation here is that the reasons for not being supportive were not collected.

96.63% (N=86) said they would be supportive of the anonymous data collection of the number of clients impacted by PPAU through reporting to a central database such as the Health Research Board.

Asking clients about Parental Problem Alcohol Use

Roughly one quarter of MH professionals (24.19%, N= 30) reported that they routinely ask their clients if they have experienced PPAU regardless of their presenting issue. 22.58% of MH professionals (N= 28) reported that they probably would ask. MH professionals who

experienced PPAU themselves growing up were 3 times more likely to fall into either one of these categories. Addiction counsellors were most likely to ‘routinely ask and probably ask’(64.29%). followed by 63.63% for Cognitive Behavioural Therapists,58.34% of Clinical Psychologists , 54.54% of Mental Health Nurses and 51.85% of Psychotherapists). MH professionals who had not received PPAU training were less likely to ask their clients. More specifically, 100% of MH professionals (N=15) who definitely do not ask about PPAU, and 80.95% (N=17) of those who probably would not ask, had received no specific PPAU training.

The participants who reported that they do not always ask if their clients have experienced PPAU, were then asked in question 18 to specify if there were certain presentations in which they would. This question was analysed using thematic analysis. A total of 61 participants responded to this question, 12 of which were omitted from the analysis as they did not provide a clear answer to the question. 4 themes emerged from the data (A selective approach to enquiry, Intergenerational problem substance use, Universal Screening for PPAU, The exploration of PPAU only when disclosed). Each theme describes four different approaches the MH professionals had in relation to asking their clients about their experiences of PPAU.

Table 2

Different approaches to the enquiry into clients experience of Parental Problem Alcohol Use

Themes and Subthemes	**How many participants mentioned it**

A selective approach to enquiry	**24**
- Childhood difficulties	17
- Impact on functioning	8
- Mental Health Diagnosis	7
Intergenerational problem substance use	**13**
Universal screening for PPAU	**12**
The exploration of PPAU only when it is disclosed	**6**

Note. This table shows the themes and subthemes that were found when thematically analysing question 18. This question asked participants, if they do not always ask about PPAU, are there any certain presentations in which they would. Each theme represents a different approach discussed by the participants. This table demonstrates how many participants fell into each approach/ theme and subtheme.

The most prominent theme that emerged was **A selective approach to enquiry**, this contained a number of subthemes. This theme represents MH professionals who ask about PPAU when their client is presenting with specific difficulties. The presentations reported by participants (e,g, childhood abuse and neglect, depression and anxiety) are prominent in the

PPAU literature. These difficulties were then further categorised into three subthemes 'Childhood Difficulties', 'Mental Health Diagnosis' and 'Impact on Functioning'.

The most frequently mentioned issues were those related to childhood, which constituted the subtheme 'Childhood Difficulties'. These included issues that emerged in the client's early life, these were mostly related to family dynamics. Participants mentioned the following ACE's "*childhood adversity… abuse….neglect …difficult upbringing… trauma… chaotic homelife… absent parents… problems with meeting the needs of the children… ruptures in early childhood and adolescence… When youngsters report difficulties in relationship with parents*". It is well established in the literature that PPAU is often experienced in conjunction with other adverse childhood experiences such as those identified above. The second subtheme was Mental Health Issues, in particular depression, anxiety and personality disorders, which, also supported existing literature. The third subtheme was Impact on functioning, where the client is experiencing difficulties across various domains in their life. The most common being financial issues, followed by relationship difficulties, trust issues, '*low self-esteem… negative core beliefs', 'non-school attending.. early school leaver… criminal activity'* and negative feelings such as '*anger… shame… perfection'.*

The presenting issues reported by these participants that warrant a specific enquiry into the presence or history of PPAU in clients, accurately mirror the co-occurring risk factors identified in this study. This indicates that the understanding MH professionals have of the common co-occurring risk factors effectively guides the identification of this issue in clients.

The second, most prominent theme was **Intergenerational problem substance use** . A total of 7 participants stated addiction issues as the sole reason for enquiring about PPAU, '*if presenting problem is substance or alcohol use'.*

The third theme was **Universal screening for PPAU**, where mental health professionals stated that they assess if the experience of PPAU is present in each client during an initial assessment. *"I take a comprehensive history on first assessment session with all clients and ask specifically if there was any problematic alcohol use in their family of origin"*. 4 participants specified that this initial assessment took the form of an ACE questionnaire, "*As general assessment for all mental health disorders, I would use ACE scale*".

The most frequent occupation found within this theme of universal screening were those who worked in addiction, where two thirds of them, such as addiction counsellors, drugs workers and addiction outreach workers stated they would ask about it in initial assessment.

This may be explained by the focus of addiction workers being on the causes of their clients problem alcohol use. Research has shown the experience of PPAU is highly prevalent amongst those who develop PAU. This can be explained by environmental and genetic factors, or an interaction between the two. However, it is also well documented that PPAU is highly prevalent in those who experience depression, anxiety and a wide range of other mental illnesses. This suggests that a universal screening for PPAU would be equally appropriate in more general mental health services which deal with a broad range of presenting issues.

The final theme was **The exploration of PPAU only when disclosed**. "*When asking about childhood the client might bring it up but I don't ask specifically about parental alcohol use or abuse*." This group of participants do not ask their clients if they have experienced PPAU, even if they are presenting with issues that are associated risks within this population. This has the potential for PPAU to go unnoticed and unaddressed. Stigma and shame are the

biggest barriers to treatment in this population and it is therefore necessary that all MH professionals show an openness to the topic through gentle enquiry without judgment. Conflicting approaches to addressing the topic of PPAU emerged. Most seem to only ask when there are explicit markers for the issue, this can be quite a broad range of presenting issues. Some incorporated it into an initial screening. This may be a highly appropriate way to identify the issue that may be otherwise difficult to address due to common feelings in this population of shame, stigma and the need to keep it a secret. Some MH professionals reported there is something inappropriate about asking about PPAU outright.

Risk and Protective Factors identified in clients impacted by Parental Problem Alcohol Use

Q 22. What are the co-occurring risk factors (environmental or biological) that are most commonly found in the lives of adults who grew up with up with parental problem alcohol use in your professional experience?

A total of 83 participants responded to this question, 17 of which were discarded for incompleteness. Most of these responses discussed the consequences of PPAU in adulthood and how it affects the clients own parenting styles. Content analysis was utilised.

Table 3

Categories of common co-occurring risk factors in the lives of those affected by PPAU according to Mental Health Professionals

Category	Codes (number of participants)
Low Socioeconomic Status	Low SES backgrounds, Poverty, Finances, Social Housing, Poverty and other adverse social settings, Poor Housing, Deprived area, Poor working conditions of parents, Intergenerational labour force exclusion, homelessness, unemployment (23)
Mental Ill Health	Anxiety, Depression, Ill mental health, untreated mental health, depressive symptoms, social anxiety, dual diagnoses in parents, eating disorders, self-harm , intergenerational ill mental health (18)
Impaired Education	less educated, educational and career disadvantages, poor achievement, underachievement, problems with information retention, Lower education of parents, early school leaver, less access to education, having educational needs focus and attention, poor employment prospects
Neglect	Neglect, emotional neglect, deprivation. (11)
Relationship Issues	Relationship issues, Difficulties with trust, insecure relationships, difficulties with connection, difficulty to communicate, inability to form lasting stable relationships,

Emotional and behavioural Issues	Poor stress management and emotional regulation, Emotional difficulties, anger, stress, fatigue, burnout, risk taking behaviours, supressing feelings, drug or alcohol dependence, addiction, personality issues, poor sense of
Inter-parental relationship issues	Domestic Violence, gender- based violence, Dysfunctional marriage, parental separation, parental criminality and conflict (7)
Poor Self Esteem	Low self-esteem, Poor confidence (6)
Lack of external supports	Lack of community resources, lack of other secure adults, lack of early intervention psychological services, lack of supports, lack of stable environment beyond the parents, culture of normalizations of alcohol. (5)
Abuse	Abuse, sexual abuse, emotional abuse (3)
Impaired Parenting	Chaotic lifestyle, Poor attachment style, absent parenting
Ill Health	Chronic Illness, poor health (2)
ACE's	Other ACE's (2)

Note. The column on the left illustrates categories of risk factors mentioned by participants. The column on the right illustrates an exhaustive list of what codes went into each of these categories. The right column also includes the number of participants that contributed to each category which are included in the brackets.

Q 23. Have you recognized any particular protective factors in terms of severity and treatment response in adult clients who experienced PPAU?

This question asked participants if the severity of the presentations and/or responses to treatment in this population were buffered by any particular protective factors. 72 participants responded to this question. 13 of those responses were discarded as they did not mention protective factors, most instead discussed negative consequences of growing up with PPAU. Out of the remaining 59 participants, 30.5% (N=18) said there were no protective factors found in this population in relation to severity and/or treatment response.

The most common category of protective factors found was **One Good Adult** (N=25), where participants discussed relationships with an adult, both within and external to the family home, that acted as a buffer to the potential adversity cause by their experience of PPAU. This good adult could be in the family, at school, at a friend's house. The notion of a role model was also evoked but was not specified.

The second category of protective factors referred to particular **traits and skills**. Traits listed included extraversion, intelligence, creativity, having an internal locus of control.

Education, hobbies and community resources (N=10) were a category of protective factors identified by the MH professionals. These were activities outside the home in school and the broader community. Specifically mentioned was the engagement and achievement in education hobbies, music, sports, clubs and other community facilities. Social supports including good friendships was also mentioned.

The fourth category was **Psychoeducation/ Awareness** (N=5). This was mostly described as when the client had gained an understanding of their situation. This was achieved through high levels of self-awareness and a recognition of their lack of control of their situation as a child. It was often achieved through therapy, and through an exploration of their past experiences.

Therapy Having a professional to talk to about their experiences, in particular extended counselling support, was mentioned as a protective factor for the prevention of later life difficulties.

The sixth category was **Learning from Parents Alcohol use** (N=4) where MH professionals reports clients describing that they want to avoid the situations they witnessed their parents and themselves live in. Their experience caused them to want the opposite for themselves when they had the control to do so in adulthood. This was a protective factor in relation to developing problem alcohol use themselves, however it may not be a protective factor in relation to the other effects their PPAU caused.

Table 4

Categories of protective factors found in the lives of those impacted by PPAU according to Mental health Professionals

Categories	Codes (number of participants)
One Good Adult	Support systems, trauma bonding with siblings, One Stable Parent, secure attachment style, Other supportive adults, supportive relatives, Connection, Teachers to talk to, One Caring adult, mentor or positive role model, one stable healthy role model. (25)

Traits and skills	Resilience, high level of survival skills, coping skills, less disassociation, Outgoing, intelligence, Creativity, internal locus of control. (14)
Education/ hobbies and community resources	Academic achievements, education, hobbies, music, sports, clubs Community facilities and groups, social support, activities outside the home, good friendships. (10)
Psychoeducation/ Awareness	Psychoeducation, awareness that the issue was not theirs, recognize dysfunction of parents, self-awareness. (5)
Therapy	Open to talk about it, Counselling, Extended counselling support, Professional to talk to, has programme goals. (5)
Learning from Parents alcohol use	Try to right the wrongs, motivated to wanting opposite experience, strong adverse attitude to alcohol, often do not drink. (4)

Note. This table demonstrates the categories of protective factors found in clients who have experienced PPAU according to mental health professionals.

Discussion

To the best of our knowledge, this was the first investigation into the awareness, knowledge, understanding and training that mental health professionals have on parental problem alcohol use in Ireland. This study was conducted in collaboration with University College Cork (UCC) and Silent Voices, Alcohol Action Ireland which consisted of a purpose- built explorative survey. This study confirmed the need and want for a significant increase in the level of training that all mental health professionals receive on issues related to PPAU.

This study found that clinically focused professionals had very low levels of PPAU training in comparison to therapeutically orientated professionals. This is concerning given the high prevalence of PPAU in clients with moderate to severe mental health issues such as depression (Anda et al., 2002; Klostermann et al., 2011). This indicates that clinical populations, i.e. those who have the most severe mental health outcomes, do not have access to services that are specifically trained to deal with their experiences of PPAU. Such findings demonstrate an increase of PPAU training in clinical settings is required. Further research is required to understand why there is a lack of training for clinically focused mental health professionals and determine if there are any existing barriers to accessing it.

The mental health professionals who seem to be most equipped to deal with the issue of PPAU are psychotherapists as these professionals had the most PPAU specific training compared to other occupations.

PPAU training was found to be beneficial as it increased the likelihood of it being addressed by professionals in mental health settings. This is a goal outlined in the literature which emphasises an active approach to the issue grounded in knowledge, understanding and non-judgement Anda et al., (2002) (Turning Point, 2006).

The detection of a mental health diagnosis did not significantly influence an enquiry into PPAU. This approach contradicts with previous literature that suggests mental health diagnosis are very common in this population (Raitasalo et al., 2018). This suggests an increase in training is needed that focuses on the effects of PPAU on mental health throughout adulthood, and how this understanding can guide a more widespread approach into PPAU and its detection in clients. However, this study did not collect specific information on MH professionals understanding of the effects of PPAU on mental health throughout adulthood. Further investigation into this would provide more specific guidance for the design of future PPAU training.

The majority of professionals enquired about PPAU when they considered co-occurring risk factors present. This demonstrated a practical benefit to the understanding of such risk factors. However, there were some MH professionals (20.48%, N= 17) who seemed to lack an understanding of co-occurring risk factors. All of the risk and protective factors mentioned

by MH professionals have been previously outlined in the literature, indicating that they are well established (ADCS, 2021; Haugland & Elgá, 2021; Velleman & Templeton, 2018).

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This study confirms previous studies which demonstrate the significant level of co-occurring ACE's this population faces (Velleman & Templeton, 2007) (Cleaver, 2008) (AAI, 2022). Our results show mental illness, neglect, domestic violence, separation and abuse to be co-occurring issues. Thus also confirming the notion of a particular harmful of clustering risk factors known as the 'trigger trio' including PPAU, mental illness and domestic violence (ADCS, 2021). Other co-occurring risk factors highlighted in this study, in descending order of frequency were low socioeconomic status, impaired education, relationship issues emotional and behavioural issues, poor self-esteem, a lack of external supports, impaired parenting and ill health.

The literature review conducted for this study demonstrated that the research investigating the relationship between PPAU and socioeconomic status (SES) is complex and often contradictory. The results of this current study support those that demonstrate a positive association, as low SES was the most frequently mentioned co-occurring risk factor found in clients who experienced PPAU (Haugland & Elgá, 2021). However, these findings may suggest, not that PPAU is more prevalent in families of a lower SES, but rather children who experience PPAU and low SES are more likely to experience negative outcomes as a result of the compounding adversities they face.

The presence of one good adult was the largest protector factor identified in this study, which supports previous findings in the literature (AAI, 2020).

The importance of relationships, education and external supports were identified in both risk and protective factors, indicating their specific importance for this population.

It showed that having impaired, insecure relationships that lack trust and effective communication is a common co-occurring risk factor, but also, that having the opposite, i.e.. healthy stable relationships with at least one good adult, sibling or friend, are common protective factors. Education was also identified as both a risk and protective factor. Specifically, children growing up with PPAU are at particular risk of problems with information retention, school attendance and access to education, but also that engagement with education can buffer the impact of their adverse experiences. External supports, such as community resources and accessable therapy were found to be a common co-occurring risk factor when absent, as well as a protective factor when present.

These findings suggest interventions combining these three factors; relationship building, an engaging education system and accessible external supports, will be most beneficial to this population, as these resources, or lack thereof, have the potential to make a positive or negative difference in how children are affected by PPAU. This may include the provision of trauma-informed training to all educators in order to increase detection of PPAU, as well programmes that can identify children impacted directly through an inter-agency approach, such as Operation Encompass.

Limitations and Future Research

The main limitation to the current study is the small sample size (N=132). Distributions between occupations were also uneven, making comparisons difficult.

Due to the nature of a short 10-mintue survey, the qualitative responses in this study were very brief. This area of research would benefit from more in-depth conversations with MH professionals in which they can expand on their experiences of working with clients who have experienced PPAU. This would allow a more in depth understanding of the presentations, risk and protective factors and their mechanisms.

The exploratory nature of this study enabled the identification of future research enquiries. These included, why is there an absence of PPAU specific training in clinically focused services, and are there any barriers to such training? What is the true prevalence of PPAU training in a large sample of MH professionals? What relationship building interventions are most suitable for those who experience PPAU and other forms of adversity? And finally, what community resources are currently available to children and adults who are impacted by PPAU?

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Appendix 1

Information Statement

Thank you for considering participating in this research project. The purpose of this statement is to explain to you what the work is about and what your participation would involve, so as to enable you to make an informed choice.

The purpose of this study is to understand the knowledge and training Mental Health Professionals have in relation to Parental problem alcohol use and its impact on childhood and/or adulthood. Problem alcohol use is defined as exceeding the weekly limit of 21 standard drinks for a man and 14 standard drinks for a woman that can cause harm to physical health, psychological wellbeing and relationships. (Mongan, 2007). Should you choose to participate, you will complete a survey containing 19 questions taking between

10-20 minutes, which will include items on your type of mental health profession, knowledge of the prevalence of Parental problem alcohol use, training received on issues, presentations and treatments specifically relevant to children and adult children of alcoholics. Questions will also be asked about experiences of treating clients who are children and currently living with parental alcohol use and adult children of alcoholics including accompanying risks, protective factors and the role it plays in mental health difficulties.

Participation in this study is completely voluntary. There is no obligation to participate, and should you choose to do so you can refuse to answer specific questions, or decide to withdraw from the study up until submission. All information you provide will be confidential and your anonymity will be protected throughout the study. Any responses that may be allow you to be identified will be omitted from the data. IP addresses will not be collected at any point, meaning the data you provide cannot be traced back to you

Due to the anonymous nature this study it will not be possible to withdraw your data after submission.

The anonymous data will be stored on the University College Cork OneDrive system and subsequently on the UCC server. The data that possibly contains any identifying information will be stored on an encrypted computer. The data will be stored for an indefinite amount of time in a data repository to allow data accessibility for future studies. The information you provide may contribute to research publications and/or conference presentations. This data will contribute to a Final Year Project and possibly a research paper.

We do not anticipate any negative outcomes from participating in this study. Should you have any concerns arising from participating in the research, or should it raise any issues for you, the contact details for support services provided below may be of assistance.

This study has obtained ethical approval from the UCC School of Applied Psychology Ethics Committee.

If you agree to take part in this study, please complete the consent form overleaf.

If you have a concern about how we have handled your personal data, you are entitled to this raise this with the Data Protection Commission.

https://www.dataprotection.ie/

UCC'S Data Protection Officer (DPO) is Catriona O'Sullivan, Information Compliance Manager, University College Cork, 4 Carrigside, College Road, Cork, Ireland.

Telephone: +353 (0)21 4903949* Email: gdpr@ucc.ie

The Data Controller for this study is Dr Sharon Lambert

Contact details: Email: Sharon.lambert@ucc.ie _Phone: 021 4904551

If you experience any distress as a result of completing this study, the following resources may be helpful for you:

Silent Voices website provides key supports for those who have experienced Parental Alcohol Dependence http://alcoholireland.ie/silent-voices/resources/

Turn to me offers peer support groups to professionals that are available through their website https://turn2me.ie

Text about it on 50808 can provide emotional support to people dealing with small and big mental health issues

116123 Samaritans provide non-judgemental support for people experiencing distress or despair

The HSE provides an online stress control class that are available via https://stresscontrol.ie

Aware on supportmail@aware.ie 1800 80 48 48 provides services to those dealing anxiety, mild to moderate depression and mood disorders as well as friends and family support

Appendix 2- Questionnaire

Information statement will appear here

Do you consent to participate Yes No

1. What is your gender?

Drop down menu

Male

Female

Non- Binary/ third gender

Other

Prefer not to say

2. Please select your age range

Drop down menu

20-30

30-40

40-50

50-60

60-70

70+

3. What is your current occupation?

Drop down menu

1. Clinical Psychologist

2. Counselling Psychologist

3. Psychiatrist

4. Psychotherapist

5. Cognitive Behavioural Therapist

6. Counsellor

7. Addiction Counsellor

8. Mental Health Social Worker

9. Mental Health Nurse

10. Psychiatric Nurse

11. Vocational supports trainer

12. Other (please outline)

4. In which type of setting are you currently working in?

Drop down menu

1. Hospital
2. Private sector
3. Prison
4. University/school
5. Community sector/NGOs
6. Public sector
7. Other please specify (comment box)

5. Who do you work with?

Drop down menu

1) Adults

2) Children

3) Both

6. How long have you been in your current role?

Input number

7. Have you received any training specific to problem alcohol use?

Yes or no tick box

Comment box

If yes, please indicate the level of training received and/or any comments

If no would you have liked to have been given that training

8. Did you personally experience problem parental alcohol use as a child?

9. Do you routinely ask clients irrespective of presenting issue if they have experienced parental problem drinking?

   If no, are there categories of presenting issues where you would ask this question

   If yes, then please list those issues

10. Out of an adult population of 3.7 million, how many adults would you estimate have grown up with Parental Alcohol Dependence?

Drop down menu

Less than 50,000

Less than 100,000

less than 250,000

less than 400,000

less than 550,000

11. What are the most frequent struggles potentially faced by a child and or adult clients growing up with problem parental alcohol use? Please rank these in order of frequency of presentation.

Rank Order

Physical and emotional Abuse

Eating Disorder

Physical and emotional neglect

Depression

Anxiety

Alcohol Dependence

Abstraction and Conceptual reasoning

Problems with academic achievement

Other :

12. What percentage of your clients do you estimate have experienced parental alcohol problem use?

Drop down menu

Less than 5%

5-10%

10-20%

20-35%

35-50%

50-65%

65-80%

80-100%

Please indicate the approx. number of clients this translates to.

Insert number

13. What are the co-occurring risk factors (environmental or biological) that are most commonly found in the lives of adults who grew up with up with parental problem alcohol use in your professional experience?

Comment box

14. Have you recognized any particular protective factors in terms of severity and treatment response in adult children of alcoholics (ACOA's) versus non-ACOA's

Comment box

15. Is there anything you would approach differently in your practice with a client who has experienced parental problem alcohol use versus a client who did not experience it?

Comment box

16. What supports are needed when working with children and adults affected by Parental problem alcohol use?

Comment box

17. Would you be supportive of all mental health services collecting anonymous data on the numbers of people impacted by parental problem drinking and reporting these figures to a central database such as the Health Research Board?

    Yes or No

18. Would you be supportive of all mental health professionals being trained to a minimum degree to identify children who are experiencing parental problem alcohol use ?

Yes/No

If yes, what knowledge and skills would this entail?