ORIGINAL ARTICLE

(Self)Organizing Potential of European Parents to Prevent Children from Alcohol, Tobacco and Other Drug Use

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BACKGROUND: There is little scientific evidence on how parents and caregivers organize and empower themselves to reduce ATOD use in their children. METHODS: Multi-site qualitative study, focus groups data were analyzed and interpreted using itemization, clustering, categorization, contrasting, and comparison. SAMPLE: A total of 85 parents/caregivers and parent association members (62 female and 23 male parents, average age 44.4 years) from six countries participated in 12 focus groups, using convenience sampling and purposive sampling methods. FINDINGS: Our data suggests that parents and caregivers perceive the potential to self-organize at the local community and school level to be low. Parents provided solutions on how to improve self-organisation; i) empowering parents through (keen) interest in their child; ii) development of intensive collaboration with schools, facilitated by school representatives; iii) collaboration with prevention professionals. CONCLUSIONS: Our findings may support the development of parental guidelines designed to increase the empowerment of European parents to take part and lead community based substance use prevention activities.

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1 INTRODUCTION

The use and misuse of alcohol, tobacco and other drugs (ATOD) in minors constitutes a long term and serious problem worldwide, with major health, social, and economic consequences (e.g.Gore et al., 2011).The European School Survey Project on Alcohol and Other Drugs (ESPAD) or the Health Behavior in School-aged Children (HBSC) studies show high rates of ATOD use in underage populations across all European countries (Hibell et al., 2012; Currie et al., 2012).

The initiation and developmental trajectory of ATOD use in children adolescents, and young adults are influenced by various risk and protective factors(Hawkins, Catalano, & Miller, 1992;Stone, Becker, Huber, & Catalano, 2012), including those at the level of individual, family, school, and society (National Institute on Drug Abuse, 2003; Ostaszewski & Zimmerman, 2006;Wang, Hsu, Lin, Cheng, & Lee, 2010).Of risk factors identified those related to family rank among the most influential, particularly in early adolescence before peer influence comes to the fore (Allen, Donohue, Griffin, Ryan, & Turner, 2003). Parental behavior, particularly parenting styles, parental communication and parental control, and the extent of alcohol use in the family have all been linked to adolescent ATOD use (e.g.,Becona et al., 2012;Belles, Budde, Moesgen, & Klein, 2011;Burk et al., 2011;Cleveland, Feinberg, & Greenberg, 2010;Orosova et al., 2007;Tobler, Komro, & Maldonado-Molina, 2009;van der Vorst, Engels, Meeus, & Dekovic, 2006).

Recently, a number of prevention interventions targeting families have been developed and evaluated in the United States and Europe. Systematic review indicates that some of these are effective in reducing adolescent ATOD, and produce small but persistent medium and long term effects(Foxcroft & Tsertsvadze, 2011;Gates, McCambridge, Smith, & Foxcroft, 2006;Thomas, Baker, & Lorenzetti, 2007).One exemplar programs showing promising results is the Strengthening Families Program (SFP), originally developed and extensively evaluated in the U.S. (Riesch et al., 2012) and more recently adapted for delivery in Europe (e.g., Coombes, Allen, Marsh, & Foxcroft, 2009). Such interventions, aimed at training parents or helping parents cope with family problems, are usually designed and delivered by prevention specialists and aim to improve parents' skills inside the families. However, such interventions rarely support the development of prevention capacity of individual family members, or the interaction of the family with their social environment. Whilst the (cost) effectiveness of formalized prevention interventions has been demonstrated, initial delivery is often expensive and requires the participation of skilled practitioners (Coombes, Allen, Marsh, & Foxcroft, 2009), which may limit implementation opportunities, particularly in those countries with a less well-developed prevention infrastructure (EMCDDA, 2012). Furthermore, the effectiveness of manualised approaches to prevention, are highly sensitive to adaptation in difference geographies and delivery systems (e.g.Ferrer-Wreder, Sundell, & Mansoory, 2012).

A different approach to improve the influence of parental activities over children's ATOD use is through parents' own (informal) initiatives, i.e. the formation of groups in order to empower themselves. Empowerment provides individuals, organizations, and communities with greater control, efficacy, and social justice through direct participation (Rappaport, 1987). The idea of empowerment was developed in the 1950s and systematically studied from the 1980s, with the later addition of parental empowerment (e.g., Cochran, 1990;Kasmel & Tanggaard, 2011;Gonzales et al., 2011). Empowerment may be viewed as a complex concept of interrelated components that interact on the level of self-perception, understanding the environment, and actions taken to directly influence outcomes (Zimmerman, 1995).

However, there is little scientific evidence on how parents and caregivers organize and empower themselves with the aim of reducing ATOD use in their children. The current study is part of a wider EU funded initiative which aimed to develop guidelines in order to support family empowerment and involvement in prevention activities (European Family Empowerment project).As part of this work we facilitated a series of focus groups (FG) in participating countries in order to explore the range of actions parents undertake in order to organize themselves in response to their children's (potential) ATOD use and what more effective ways to (self)organize might be.

2 METHODS

2 / 1 Study design

This was a multi-site qualitative study conducted with parents/caregivers of adolescent children, and parent association members, in the Czech Republic (Olomouc [CZ]), Portugal (Coimbra [PT]), Spain (Mallorca [ES]), Slovenia (Ljubljana [SL]), Sweden (Stockholm [SW])and the United Kingdom (Liverpool [UK]), between March and July 2012. Focus Group settings varied between each country and included family homes, research institutions, and

Researchers in each country used a standardized Protocol on Qualitative Data Collection in order to make sure FGs are precisely scheduled and carried-out and standardized methodology is used. Qualitative Data Transcription and Codification Manual, and Analysis Manual were developed by the lead authors and used in each study site (available upon request). The proceedings of each FG were recorded, transcribed and analyzed in accordance with this manual (see below). Initial thematic data analysis was con-

ducted in the national languages (Czech, English, Portuguese, Slovenian, Spanish, Swedish) and translated into a country report, written in English. All country reports were submitted to the lead authors who undertook secondary analysis and synthesis of data in order to provide this international perspective.

2 / 2 Study population

A total of 85 parents/caregivers and parent association members were recruited by the six study partners. Respondents were recruited using convenience sampling and purposive sampling methods (Miovsky, 2006). Respondents were contacted mainly through cooperation with elementary schools, through family and prevention associations and/or cooperation with local action groups in drug prevention. The following sampling preferences were emphasized: ideally an equal ratio of male: female in each of the FG, representation from a range of different socio-economic strata, single parents should be represented but shall not constitute more than half of FG respondents, and only one parent from each family was to be present. Age and number of children were not determinants of FG composition. Participation in the FG was conditioned upon receiving informed consent. Participants were not paid for taking part.

In total, the study involved 62 female and 23 male parents, aged between 33 and 58 years (mean age 44.4 years), with most families having two children (49 participants). See *Table 1* for country specific information on the sample.

Focus Groups

Focus Groups were held with between 4 and 15 respondents and lasted approximately 90 minutes. Despite the small number of (four) participants in three FGs we have not considered these as Group Interviews (Miovsky, 2006). FG moderators ensured that each participant was familiar with common FG rules (Morgan, 1997; Krueger & Casey, 2000; Greenbaum, 2000), such as respect for diversity of opinion, allowing other members to speak, and the right not to answer etc.

Once each FG was completed moderators immediately wrote a short report which included overall impressions, thoughts notes, relevant incidents, and to draw a 'map' with brief description of participants. This allowed for reflection when country reports were written at a later date.

Data management, analysis, and interpretation

The voice-recorded transcripts were analyzed, using similarity and contrast techniques, as well as intuitive approach to data analysis (Miovsky, 2006). All study partners were asked to use a Reporting Grids (RG) template for reporting of the national data. We adapted the Reporting Grids from the work of Howard and colleagues (1998). The purpose of using the RG was to guide the structure and content of the findings made by each national research team. RG were designed to provide an overview of key findings, and were used as the basis for synthesis and presentation of the most important findings that emerged from the analyses (Howard, Rhodes, Fitch, & Stimson, 1998). Each RG usually represented one 'Key Question' that was followed by a 'Findings' overview, providing a succinct but clear overview of the most important findings. Representative responses were included in each RG which were considered the most representative quotes, with an indication of frequency of agreement – this allowed us to recognize emerging consensus. Contradictory responses were also included in order to represent diversity of opinion and disagreement. General comments and researcher identified methodological issues were also collected within each RG. The use of the standard RG allowed us to directly compare and synthesize findings from different countries.

Once each researcher had reached the point of 'saturation' in the key areas of study interest, the data collected from each of the key questions were compiled, and used as a basis for making judgments about how to present the overall key findings on the RG. There were approximately 15 RG (ranging from 9 to 18) produced by each partner.

All research translated their national reports in English and submitted it to one researcher (RG) who conducted a second round of analysis and interpretation. This analytical work was conducted using the method of inductive analysis (Miles & Huberman, 1994). The following procedures were incorporated into the analysis; itemization, clustering, categorization, contrasting, and comparison (Miles & Huberman, 1994). The diversity and lack of homogeneity between the various sources necessitated the consistent enforcement of data validity checking techniques (Cermak & Stepanikova, 1998) (Miovsky, 2006).

Ethical approval

Ethical approval was obtained in accordance with each research partner's Institute and country's research governance procedures.

3 RESULTS

3 / 1 Parents and community

Parents generally praised the establishment of community driven support groups that could serve as platform for sharing parental advice. Nevertheless, based on a historical lack of such approaches, some participants expressed concerns:

"I think it's a really good thing if communities spring up and do things together, but… I'm a bit skeptical…" [UK]

Parents also seemed hesitant about responding to ATOD in other families, largely because of the complex nature of the issue and perceptions of the 'types' of families where ATOD took place:

Table 1 / Tabulka 1

Country specific characteristics of the focus groups respondents

Charakteristiky účastníků ohniskových skupin dle jednotlivých zemí

Country		Slovenia	Portugal	Sweden	Spain	UK	Czechia	TOTAL
Number of FGs		2	1	1	3	2	3	12
Age average		42,4	44,5	44,3	46	46,7	42,5	44,4
interval		33-49	37-48	39-52	35-58	38-58	39-48	33-58
Gender	*Male = 1*	6	4	0	4	3	6	23
	Female = 2	24	4	6	9	8	11	62
Highest achieved education	*1 = Primary school*	-	.-	-	-	-	1	1
	2 = Apprentice training school (non-graduate)	-	1	-	-	3	7	11
	3 = Apprentice training school (with graduation)	14	1	3	8	-	8	34
	4 = University graduate	14	6	3	5	7	1	36
	5 = Other	2				1		3
Economic activity in past 3 months	*1 = Pupil, student*	-	-	-	-	-	-	0
	2 = Steady job	24	5	6	11	6	14	66
	3 = Occasional job	1	-	-	-	-	-	1
	4 = Unemployed on benefit	-	-	-	-	-	-	0
	5 = Unemployed (signed off)	-	-	-	-	1	-	1
	6 = Pensions, disability benefits	1	-	-	1	1	-	3
	7 = Illegal work							0
	8 = Housewife	4	-	-	1	3	1	9
	9 = Other	-	3	-	-	-	2	5
Marital status	*1 = Single*	-	-	-	-	2	-	2
	2 = Living with a partner	6	1	6	1	1	5	20
	3 = Married	20	7	-	10	8	11	56
	4 = Divorced	2	-	-	2	-	1	5
	5 = Widowed	1	-	-	-	-	-	1
	6 = Re-married	1	-	-	-	-	-	1

"And their parents [i.e., of children who may be experiencing difficulties with substances] are usually the ones that you probably wouldn't want to confront anyway" [UK]

Different types of school groups and parents' associations, with a cohesive history of providing informal family support also faced challenges in engaging parents whose children were considered to be at most risk of problems related to ATOD use:

„...it's a bit like preaching to the converted, to be honest, because the mums that would join those groups [i.e. informal neighborhood/parent support groups] are the mums that probably wouldn't have problems with drink [i.e. alcohol use in their family]*."*[UK]

One participant from a Spanish FG provided one explanation for this frequently reported observation, that was representative of perceptions across our sample:

"Parents are afraid of opening the doors of their homes. Those who have problems at home are afraid of showing them, of sharing them with others. Each one searches for individual solutions."[ES]

According to participants, parental involvement in regular children's extracurricular activities, even without a focus on ATOD, was still limited:

"The main problem is that parents don't want to get involved in extracurricular activities. They are tired and it requires effort on their side …it requires involvement. You

have to get up on Saturday or Sunday and go to the field to watch the game and be with them." [ES]

Hence, encouraging parents to become involved in activities that addressed problem behaviours such as ATOD use would require greater effort than simply observing activities.

In summary, it was believed in all countries that developing (in)formal community networks of parents would be problematic. Firstly, children's ATOD use was viewed as a private family matter that would, at most, be shared with close friends, and certainly not the wider community. Secondly, it was believed that there would be great challenges in encouraging at-risk parents and families to participate in parent and community groups, especially in response to such stigmatized behaviour as problematic ATOD use.

Schools as a facilitator of action

When children are young (first years of school attendance) parents regularly meet at the school gate, at more likely to know each other personally, and are more eager to meet and share. However, as children age and gain independence (such as through travelling to school alone), the number of occasions when parents of school attending children meet decreases. Children's early schools years were also seen as a time of shared novel experience, where parents could discuss common issues that many were encountering for the first time. With time, increased parental experience meant that this informally shared learning was less prominent:

"…mums don't talk as much, or parents don't talk as much…we don't meet at the school gates."[UK]

However, among parents who knew each other well, it was still possible to share experiences and advise on ATOD related problems. However, this was considered more of a domain of mothers than fathers:

"Among mothers we talk... Things they do, things children tell us, how we do things to act more accurately..." [ES]

However, in contrast to many other family issues, talking about ATOD related issues, even between mothers, was perceived as difficult, especially with other mothers who were not close to the family:

"But even among a group of friends it's hard to reach accord on these topics, imagine doing so among a group of people you don't even know." [ES]

Despite all the concerns expressed above, the idea of developing local parental associations in prevention was, in general, perceived as worthy and was welcomed by participants. The importance of identifying a local 'champion' to take this process forward was critical to its success:

"…it would be useful to have someone who tells parents do this and that… who is respected and knows what to do and what is needed." [CZ]

Online tools were, in general, considered by the participants as a useful and practical means for keeping in touch with other parents. However, echoing wider societal debates, some parents were afraid that this would lead to a decrease in 'real-world' interactions, companionship, and community connections:

„It would be very beneficial to us, if somebody would eliminate at least half of social networks. Probably it would enable people to socialize more." [SL]

Care would also need to be taken not to exclude those groups of parents who did not use the Internet regularly (e.g. 27% of EU countries do not have a household Internet connection; Seybert, 2011):

"And I guess parents with lower income may not be using Internet at all." [CZ]

Participatory and motivational actions also need to be taken in the early phases of parental group development to avoid frustration and scepticism amongst active parents:

"…what we have done is to collaborate in parties organized by the neighbourhood or by the parish, but just in holiday celebrations." [ES]

The present level of frustration felt by some participants with the scope of activities of school-based groups may potentiate new ideas and drive change and innovation of new approaches:

"The role played by school parents' associations must be redefined, especially for secondary schools. We need to reinvent ourselves a bit. In a meeting between secondary school parent organizations to see what we all were doing we saw there was a great lack of activities undertaken..."[ES]

As indicated above, one of the locations where parents may form parent support groups and/or gather new members is on school grounds. However this is not possible without direct cooperation between school representatives and the representatives of parent groups:

"We have tried to organize debates with parents and teachers, students could also attend, to discuss issues of interest but we didn't succeed. They [teachers] didn't have much interest on it." [ES]

"Teachers wrap up their work at one or two o'clock… they rush home… they don't want to spend at school more time than they really have to…" [CZ]

Parents and schools

In general, parents valued the contribution of schools in ATOD prevention.

"I feel really positive about the input schools put in now with kids."[UK]

However, parents in most countries (represented in the sample) were not able to provide more detailed information about school-based prevention programs. They often had little knowledge of their scope and content:

"They have some kind of drug prevention… I don't know, talking about drugs or so…"

Lack of involvement in school life was regretted by parents, although some felt that they had little control over the situation. Czech parents in particular understood the lack of communication between school and themselves as a failure of the school – the school should be more active –rather than themselves.

"…I don't see any activity from the teachers towards us. Very often they are so brief in giving information. They are centered on the facts: grades – good, behavior – good… good bye."[CZ]

In some countries (explicitly Spain and the Czech Republic, and implicitly from the others) it was difficult to involve teachers in extended meetings with parents that was not primarily focused on academic issues:

"In the best times we had [meetings] *in this school… we never could count on teachers' assistance; none of them has ever come… Everyone just minds their own businesses…"*[ES]

However, to overcome this situation parents expected the first step to be initiated by schools:

"Yeah, it would be very handy if more of those things came up at school [i.e. ATOD education] *to carry it on* [at home]."[UK]

One option, mentioned by parents, on how to foster communication between parents and school was to include electronic tools:

"They [school] *should create an electronic mode of contact with parents.* [PT]

One interesting example of a school-parent communication was a Swedish school web-site that offers parents, for example, an opportunity to check the attendance of their children at school in real time. Most parents took advantage of this system and did not hesitate to attend the school or to negotiate with their children in order to improve school attendance:

"I told her…you get another chance to improve or I am taking time off work and I will sit beside you in class." [SW]

Despite emphasis placed on school outreach activities, participants still believed that parents and caregivers had to take the initiative themselves to improve collaboration. Thus, parents should be encouraged to be more active in requesting information about school activities, including what children were being taught in ATOD related lessons:

"They [parents] should not be ashamed of coming to school and find out about… things." [ES]

Based on the experiences of one participant who was also teacher involved in prevention at her school, there were different opportunities for approaching parents. The best time was when parents were actively seeking information regarding their children and educational activities.

"The only time we are able to start working with parents is at the very beginning of the school year… and only with those parents of children who are at some transition periods in the school... This is where they have to be boned up with major preventive ideas!" [CZ]

What may be a promising attempt is to involve students in prevention efforts and create a partnership between teachers, students, and parents:

"If children learn to organize in high school they can participate in more things. These associations become a nesting structure to build up more things." [ES]

4 DISCUSSION

The focus of this study was to explore the (self-)organizing potential of parents and caregivers in prevention of children ATOD use. We centred our analyses around parents and their involvement in community and school-based efforts to prevent use of ATOD. The inclusion of local community related issues illustrated the difficulties parents have in organisation.

The potential of parents and caregivers to self-organize on the local community level and school grounds was perceived by our sample of parents as rather low. However, parents indicated solutions on how to overcome the current situation: i) empowering parents through (keen) interest in their child; ii) more intensive collaboration with schools - initiated by school representatives; iii) collaboration with prevention experts.

Interesting patterns emerged from the data. While the situation in Sweden may be considered as an example of good practice in many parent-school related dimensions, on the opposite side of the continuum was the Czech Republic and Slovenia. Parents in these two countries generally perceived themselves as being very *"alienated, disconnected, and distrustful"* from formal structures. Some parents expressed that they experienced frustration and developed negative attitudes towards schools as a result of having little involvement in school life and have little or no capacity to improve this. Such feelings often resulted in externalizing this problem in such a way that the lack of communication between school and parents was perceived as a failure of the school. Such '*disconnected*' parents expected schools to be active towards parents and to draw parents into prevention. Nevertheless, regarding involvement of the 'disconnected' parents in prevention efforts in the school (or community) the key question is "how to attract parents"?

One way how to improve parental engagement in prevention activities is to empower individual parents (psychological or individual empowerment outcomes (e.g., Zimmerman, 1995), and persuade them that they are critical partners. Obtaining a better understanding of how parents perceived themselves in such prevention partnerships helped us to design the "Guidelines for Parents". The goal of the 'Guidelines' (available at http://www.irefrea.org/)is to empower the parents through provision of basic but rele-

vant information on what parents should know about ATOD and what activities parents should undertake regarding their children's ATOD use. Subsequently, the 'Guidelines' are planned to be implemented in practice, and subsequently evaluated for effectiveness. However, the 'Guidelines' are understood to be only an initial attempt of how to approach European parents. Further systematic and evidence-based work is needed.

A different perspective on empowerment is the organizational empowerment that takes into account different processes as opposed to individual empowerment (e.g.,Peterson & Zimmerman, 2004). Parents' associations and parent groups are a good example of this and represent individual parents for a common purpose. In our study, there were countries with less active parents with lower self-organizing action, e.g. Czech Republic. However, even in countries such as Spain, where parent groups and associations were active, there were problems and difficulties. The self-organizing potential of parents and caregivers is not fully optimized and, indeed, stagnation is observed. Certain levels of frustration may potentiate a need for change and invention of new approaches. One solution is to promote a so-called, expert-driven approach. The expert-driven approach can be understood as the driving force behind formative and innovative efforts, offering a 'quasi-self-forming' alternative to parents in prevention (Gabrhelik & Miovsky, 2009). Despite the fact that parent group may be created and/or, in the initial stages, led by a prevention professionals, the 'quasi-self-forming' approach offered an alternative similar to a true self-forming and independent group. One of the main assumptions within the 'quasi-self-forming' approach is that experts should step out once the group is self-reliant (Gabrhelik & Miovsky, 2009).The 'quasi--self-forming' may be viewed as an complementary process to processes on the Intraorganizational, Interorganizational, and Extraorganizational levels introduced by (Peterson & Zimmerman, 2004).

One of the platforms, where parents can meet and constitute parent groups, is on the school grounds. However, according to our participants, such initiatives are not possible without the active and direct cooperation of school representatives. This situation is, however, different to the expert-driven approach discussed above. The assumption is that the school representatives (headmaster, class teachers, school-based prevention professionals) are open to collaboration with parents and are supportive to emergence of parent groups (towards prevention).

There are several limits of the study worth noting. The first limitation was the two level analyses of the qualitative data. The country specific focus groups data were transcribed, coded and analyzed by each partner separately. All study partners were provided with detailed manuals on respondent sampling, conducting individual FGs, data management, and how to report the data (using Reporting Grids). The second level of analysis was done by one of the study partners who worked with data presented in the national reports, not with the FG transcripts. This may have affected the quality and validity of findings. Another limitation worth noting was the national reports varied in quality of reporting – not the quality of findings. We have strived to reflect this and the less detailed reports were used for validation of the findings from other partners or for detecting possible country differences. The final limitation was in the overall sample composition. Despite the sampling recommendations, the majority of respondents were women, with higher education, employed, from higher socioeconomic strata, with (reported) non-problematic children.

Despite the study limitations, the main strength of this study is the presentation of perceptions of parents on the scope and limitations in self-organizing potential of parents, based on qualitative findings from thee six European countries. We are convinced that the "voice" of parents may be useful for researchers and other prevention professionals to be "heard".

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Role of the authors: RG designed the study and wrote the core of the manuscript. HS, JB, MJ, FM, EKR, ST conducted the analyses on the national levels. AC, HS and LC contributed to the major improvement of the manuscript. All authors read and approved the final version of the manuscript.

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POSTDOCTORAL FELLOWSHIPS IN ADDICTION RESEARCH

RESEARCH

The Laboratory of Clinical and Translational Studies (LCTS) at the National Institute on Alcohol Abuse and Alcoholism (NIAAA), one of the National Institutes of Health (NIH), Department of Health and Human Services (DHHS), is recruiting for post-doctoral fellows (MD and/or PhD and/or PharmD) to conduct research in the laboratory located within the Mark O Hatfield Clinical Research Center on the main NIH campus in Bethesda, MD. The laboratory uses translational strategies and human studies, to investigate genetic susceptibility and neuroadaptive processes underlying the development of alcohol dependence and related phenotypes. The lab also conducts studies aimed at identifying potential molecular and behavioral targets for novel treatments. Specifically, current research opportunities are available at the *Section on Clinical Psychoneuroendocrinology and Neuropsychopharmacology*, a joint NIAAA-NIDA section, whose mission is to identify new pharmacological targets for addictions treatment and develop new medications for alcoholism and smoking. Research includes outpatient and inpatient studies (including human laboratory studies with neuroimaging and biobehavioral components) with a special emphasis on the possible role of feeding-related hormones as novel pharmacological targets for medications development. Candidates (MD and/or PhD and/or PharmD) should have a strong background and interest in translational and clinical addiction pharmacology.

For additional information, contact: Dr. Lorenzo Leggio, Section Chief, at lorenzo.leggio@nih.gov

Strong verbal and written communication skills are essential. Candidates should have less than 5 years of post-doctoral training. Salary will be set commensurate with experience and accomplishments. Interested candidates should apply by submitting a current C.V. and bibliography, a brief statement of research accomplishments and interests, along with 3 references. Applications can be submitted electronically or by mail to:

Laboratory of Clinical and Translational Studies
National Institute of Alcohol Abuse and Alcoholism
Mark O. Hatfield Clinical Research Center
Building 10 CRC Room 1-5330
10 Center Drive
Bethesda, Maryland 20892
LCTSResearch@mail.nih.gov
Att. Dr. Lorenzo Leggio

Refer to this website for additional information:
http://www.niaaa.nih.gov/research/niaaa-intramural-program/niaaa-laboratories/laboratory-clinical-and-translational-studies-5

The NIH is dedicated to building a diverse community in its training and employment programs. Women, minorities and persons with disabilities are strongly encouraged to apply.

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