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The Oxford Handbook of Opioids and Opioid Use Disorder

(In Progress)

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<https://doi.org/10.1093/oxfordhb/9780197618431.001.0001>

Published: 2023

Online ISBN: 9780197618462

Print ISBN: 9780197618431

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CHAPTER

The Impact of Opioid Use Disorder on Families and Children



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<https://doi.org/10.1093/oxfordhb/9780197618431.013.37>

Published: 22 May 2023

Abstract

The consequences of an opioid use disorder (OUD) and the overdose epidemic span beyond the individual suffering with the disease, as the effects of addiction ripple across the social context in which they live. Individuals with OUD have parents, siblings, children, and extended family members. This chapter summarizes existing research on how OUD and the overdose epidemic has impacted those families' members and children, in terms of short- and long-term sequelae. There is specific focus on parent/caregiver use of opioids and its impact on children under 18 years old including medical, psychosocial, and behavioral consequences. The chapter will begin by reviewing the incidence of OUD in parents and focus broadly on how OUD impacts parenting style, parent-child bonding, child maltreatment, trauma, family dissolution and removal of children from the home. The next section will discuss prevention and treatment services for families, the added burden of stigma experienced by parents with OUD and how policies are desperately needed to encourage cross-system collaboration. The chapter will conclude with a case report that illustrates much of the content covered in this chapter and a summary of evidence-based clinical recommendations.

Keywords: [opioid use disorder](#), [opioid overdose](#), [parents](#), [children](#), [family](#), [parenting style](#), [child maltreatment](#), [trauma](#), [opioid treatment](#)

Subject: [Clinical Psychology](#), [Psychology](#)

Series: [Oxford Library of Psychology](#)

Collection: [Oxford Handbooks Online](#)

Introduction

The consequences of an opioid use disorder (OUD) and the overdose epidemic span beyond the individual suffering with the disease, as the effects of addiction ripple across the social context in which they live. Individuals with OUD have parents, siblings, children, and extended family members. Family members, whether of biological origin or of choice, often have front-row seats to witness the tragedy caused by addiction that can cause deep sorrow, hopelessness, heartache, shame, and resentment. Families are the context within which children first develop knowledge, attitudes, and beliefs regarding drug use.¹ Parental, and in some cases intergenerational, drug use can create an environment in which drug use is perceived to be normative within the home even when society at-large has deemed these behaviors as illicit. Drug use and substance use disorders (SUD) can develop through multifactorial means including shared genetics and social environments.^{2,3} The heritability of OUD has been estimated to be 69–76%⁴ and an estimated 10.2% of close relatives of someone with OUD also have OUD.² Hence, it is not surprising that 30–60% of individuals in treatment for SUDs report that their parent/caregiver had problems with alcohol or drug use.^{5,6} Parental drug use is 1 dimension of adverse childhood experiences (ACEs) that have been associated with a constellation of poor health outcomes including increased risk of drug use and SUDs.^{7,8} Like individuals, families are dynamic and change over time. Families can also be a source of social support, and children often provide motivation for parents to seek treatment⁹ and commit to long-term recovery.

The purpose of this chapter is to summarize existing research on how OUD and the overdose epidemic has impacted families and children, in terms of short- and long-term sequelae. Addiction has a significant impact on the individual with the disorder and nearly everyone socially connected to them. In this chapter, we will focus primarily on parent/caregiver use of opioids and its impact on children under 18 years old including medical, psychosocial, and behavioral consequences. In most instances, the focus will be on mothers with OUD as they are more likely to be the primary caretaker for children and women spend more time on child care than men;¹⁰ further, the existing empirical research has focused almost exclusively on mothers. Most children of men who use substances have another primary caretaker (typically their mothers).¹¹ Much of the existing literature on the impact of the opioid epidemic on children and families focuses on prenatal opioid exposure and early childhood development with a few exceptions.^{6,12,13} This chapter will not cover the impact of maternal opioid use during pregnancy on neonatal outcomes and early childhood development. The chapter will begin by reviewing the incidence of OUD in parents and focus broadly on how OUD impacts parenting style, parent–child bonding, child maltreatment, trauma, family dissolution, and removal of children from the home. The next section will discuss prevention and treatment services for families, the added burden of stigma experienced by parents with OUD, and how policies are desperately needed to encourage cross-system collaboration. Given the limited number of published research studies on parental opioid use,¹⁴ data from parents with SUD will be referenced. The chapter will conclude with a case report that illustrates much of the content covered in this chapter and a summary of evidence-based clinical recommendations.

Summary of Empirical Literature

Parents with OUD

The incidence of OUD in parents is largely unknown,^{12,13} but the prevalence of parents with at-risk drug use or SUD is geographically variable ranging from 2–28%. In the United States (US), 50–79% of women in treatment for a SUD have children.¹⁵ Based on pooled data from the National Survey on Drug Use and Health (NSDUH) from 2009 to 2014, 2.9% of children and adolescents have a parent with an illicit drug use disorder and 10.5% have at least 1 parent with an alcohol use disorder in the past year.¹⁶ Data from the Behavioral Health Risk Factor Surveillance System (2011–2014) was pooled across 23 states, and 27.6% of respondents reported having a parent/caregiver who had a problem with alcohol or used street drugs.¹⁷ More recent results from the National Institute of Health's (NIH)-funded Adolescent Brain Cognitive Development (ABCD) study reported that 26.3% of youth had at least 1 parent or 2 grandparents with a history of hazardous use.¹⁸ There are significant state-level variations in OUD incidence¹⁹ and overdose rates,²⁰ presumably this data is generalizable to parents. In addition to state-level variability, there is global variability in parental incidence of SUD. In Finland, it is estimated that 3–7.2% of children have a parent with SUD²¹ and 2–3% of children under age 16 in the United Kingdom have a parent with SUD,²² even lower prevalence rates have been documented in Egypt.²³ International variability in prevalence rates likely reflect different methodological approaches across studies, as well as cultural differences. Globally, the US has the highest rate of opioid-related overdose deaths and it plausible that there are a greater number of children impacted by parents with an OUD in the US compared to other countries.

Parenting Style and Parent–Child Bonding

At-risk drug use and addiction in the family creates chaotic, conflict-ridden, and unpredictable home environments.^{5,24} It is challenging to isolate the effects of SUDs on parenting style and parent–child bonding from the effects of low education, poverty, genes, and other environmental risk factors.^{25,26} Existing research suggests that parents with SUDs have deficits in parenting skills, may act irresponsibly,²⁷ lack awareness of child developmental milestones,^{28,29} employ coercive parenting styles, use punitive discipline, and have poor communication skills.³⁰ Parents may be less able to perceive³¹ and attend to their children's emotional needs due to the direct effects of substances.³² Drug seeking behavior itself may cause parents with SUDs to be inattentive or absent for intermittent periods of time.³³ In response, role reversal frequently occurs requiring the child to assume parental responsibilities.¹ Ineffective parenting skills, coupled with parents' inability to regulate their drug use in front of their children, can be overwhelming and lead to feelings of inadequacy, guilt, and deep shame.^{5,34}

Research on parents with OUD has found parenting deficits consistent with the broader research on parents with SUDs.²⁴ Parents with OUD may be irritable, appear ambivalent, or disinterested, and they often experience problems bonding with their children.³⁵ Studies have found that there is a negative association between parental OUD and mother–child attachment, development, and child behavioral outcomes.³⁵ For example, an observational hospital-based study of newborn infants (0–1 month old) with neonatal abstinence syndrome (NAS) had decreased clarity of expressed cues and their mothers had much more difficulty responding to their infants' behavioral cues.³⁶ Mothers being treated with methadone have demonstrated difficulties in communicating emotions and being sensitive to child cues.³⁷ Parents who recognize their deficits and inability to fulfill their parental responsibilities may disengage from their children as a maladaptive coping mechanism.²⁵ The impact of SUDs on parenting is variable based on the age of the child when the parent/caregiver was actively using drugs.³⁸ Parent–child bonding is more critical during early childhood development and parents' may struggle with coercive parenting styles with adolescent-aged children. There is no research suggesting that parents with OUD have particularly poor

parenting styles or are less able to bond with their children compared to parents with other SUDs. There may be subtle differences in parents' deficits, in part reflecting their drug of choice and the effects of that drug/substance. In the context of intergenerational drug use and SUDs, parenting deficits may also be attributable to poor parental role models.

Child/Youth Maltreatment

Parents with SUDs have been shown to have deficits in emotional regulation,²⁷ poor impulse control, low frustration tolerance, and poor coping skills.²⁸ These factors may increase the risk of child maltreatment, and parents with SUDs are more likely to exhibit verbal and physical aggression toward their children.^{39,40} Maltreatment may range from neglect (inadequate parental supervision, availability of food, shelter, medical treatment, etc.) to physical and sexual abuse.⁵ A Canadian study showed a 2-fold increase in the risk of childhood physical and sexual abuse in families with parental substance abuse.⁴¹ In 2017, there were 2.4 million reports of suspected child abuse in the US with 30.8% of those involving parental/caregiver drug use. In Arkansas, Hawaii, Oregon, New Mexico, Ohio, South Dakota, and West Virginia, more than one-half of the reports resulted from suspected parental drug use.⁴² Research suggests that the majority of parents with SUDs do not have an elevated risk of child abuse potential based on standardized screening tools and depending upon the prospective validity of the screening tool, a positive screen may only mean the parent is at-risk of child abuse.⁴⁰ It is important to be mindful that increased risk of child abuse may be mitigated by non-drug using adults in the child's life/household and whether the parent/caregiver is in recovery. Research suggests that some mothers using opioids do engage in strategies to reduce the harm to their children.⁴³ Mothers often conceal their drug use from their children, and they perceive their secrecy around their addiction as a strategy to protect their children.^{43,44} Mothers that did expose their children to drug use or allowed them to see them in withdrawal reported thinking that it would deter their children from drug use.⁴³ A minority of parents with OUD are at-risk of neglecting their children, even fewer physically or sexually abuse their children.

Trauma

Trauma is a concept that has been variably defined by scholars and theorists since Pierre Janet and Sigmund Freud's writings in the early 19th century. The concept of traumatic stress and psychological stress has evolved to align with treatment interventions. The Substance Abuse and Mental Health Administration (SAMHSA) has defined individual trauma as resulting from "an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being."^{45(p.7)} Individuals with SUDs are more likely to have experienced a greater number of adverse childhood events,^{46,47,48} and women with OUD have significantly higher rates of trauma exposure.^{49,50,51} Children are witnessing non-fatal and fatal overdoses⁵² and even knowing someone who experienced an overdose can cause secondary or vicarious trauma.⁵¹ However, there is little empirical evidence on the subsequent psychological or behavioral outcomes for children whose parents overdosed. An estimated 8% of 10–17-year-olds report knowing someone who overdosed on prescribed medications.⁵³ In addition, children may be exposed to drug trafficking and related violence within their home or neighborhood, which is an independent risk factor for risky and delinquent behaviors including drug use.⁵⁴

Family Dissolution

Families with SUDs may experience periods of intermittent or sustained dissolution due to divorce, incarceration, parental loss of child custody, or parental death. In a longitudinal study of parents in methadone treatment and their children, at the 12-year follow-up 50% of the children reported having been separated from their parent for a period of time, 24% of the parents had died and only 29.2% of the parents were in recovery.⁵⁵ The cyclical nature of addiction means that a child may be reunified during periods when the parent is abstinent but may be removed again if the parent relapses to drug use. Family separation in young children (infants to 5 years of age) may negatively impact the development of the child⁵⁶ and have lasting implications. The uncertainty of separation or reunification is stressful for parents and children, plus periods of family separation may cause children to feel abandoned.⁵ Parents struggling with OUD may, formally or informally, request that other family members care for their children, which may then be the responsibility of the grandparent(s). The prevalence of grandparents or other family members caring for children whose parents have an OUD is largely unknown. A national study of mothers in treatment for SUDs, conducted prior to the opioid epidemic, found that 13% of their children reported residing with a grandparent at some point.⁵⁷ There is very limited empirical research on the impact of the opioid epidemic on grandparents or others providing kinship care. A 2020 study used qualitative interviews with a convenience sample of 15 grandparents that had taken informal or formal guardianship of their grandchild(ren) due to their adult child's use of opioids (or death) to evaluate the effects of kinship care.⁵⁸ This study documented the financial consequences faced by grandparents who either had to re-enter the workforce after retirement or had to use their retirement savings to manage the economic burden of caring for their grandchild(ren).⁵⁸ These grandparents reported that they were unable to access social services or receive financial assistance when they informally gained guardianship.⁵⁸ Grandparents reported being extremely distressed when their adult child overdosed and they had to unexpectedly take custody of their grandchildren, and in some cases, while struggling to cope with their own declining health.⁵⁸ One of the worst events that can happen to a parent is outliving their child. Grandparents who lost their child to overdose struggle to manage their own grief while also providing care for their grieving grandchild(ren).⁵⁸ Laws and regulations pertaining to guardianship of children are complicated and may be impossible to navigate without hiring a lawyer, which may not be economically feasible for those on a fixed income or those already financially struggling to provide for their grandchild(ren).⁵⁸ Given the high risk of overdose death among individuals with an OUD, presumably there are higher rates of children residing with other family members and/or in foster care compared to children whose parents have other SUDs.

Child Protective Services and Foster Care

There continues to be an escalating trajectory of out-of-home placements for children due to parental opioid use nationwide. Parental hazardous drug use is the most common predictor of out-of-home placement for children,³⁹ particularly among women with histories of childhood abuse and neglect, domestic violence, and exposure to negative events.^{59,60} Increasing rates of overdose deaths and drug-related hospitalizations are correlated with increases in child welfare cases and foster care placement.⁶¹ While rates of foster care cases decreased between 2000–2017, the proportion of cases involving parental drug use increased in children aged 6 years old or less.⁶² In 2019, 423,997 children were in foster care, and 34%⁶³ were removed due to parental drug use.⁶³ Less than half (47%) of these children were ultimately reunified with their parent or caretakers.⁶³ In addition, the highest number of children being removed from their homes are those under 1 year of age.⁶³ The rising rate of removal of young children is overwhelming the child welfare agencies. Child welfare investigations are lengthy and complex; they require an intake, screening, family assessment, and other procedures to determine if the child(ren) are at-risk in their home. In addition, the use of child welfare agencies related to illicit opioid use is costly and rising. From 2011 to 2016, 1 study estimated a 10% increase in opioid specific hospitalizations with a 1.1% increase in substantiated maltreatment reports and a 1.2% increase in foster care entry.⁶¹ Removal of a child or children from the home is stressful for the family, as well as for the system that may not have capacity to accommodate expanding caseloads. Given the strong genetic risk of SUDs, temporary placement of a child(ren) with non-drug using family members may not be possible.⁵⁷ Children with unstable home environments at a young age may have problems forming attachments,⁶² and they may have a higher risk of learning difficulties, trouble in school, mental health problems, and drug use.^{64,65} The duration of the child's placement in foster care may be long and hard to predict as it is often contingent upon the parents' ability to comply with the child welfare agency or court requirements. Delays in accessing addiction treatment and relapses, which are common during the initial stages of recovery, may further prolong the separation. Grandparents and other family members participating in kinship care may pursue adoption to provide a permanent stable environment for the child(ren), but they may not have the economic or legal resources necessary.⁵⁸ Furthermore, the decision to adopt the child(ren) may be wrought with emotion as it presumes that the parent with OUD will not recover and will be unable ultimately to regain custody of their child(ren).

Child Outcomes

Children of parents who have SUDs have an increased risk of mental health problems;^{22,66} drug use,^{21,67} including non-medical use of prescription opioids⁶⁸ and SUDs;⁶⁹ problems with academic performance;⁵⁷ and behavioral problems, such as inattention, hyperactivity, aggression, and peer conflict.^{12,22,28,70} Children of parents with SUDs may also experience difficulties learning.²⁷ At-risk or hazardous drug use leads to family dysfunction which, in turn, exacerbates parental stress and subsequent maladaptive coping may cause persistence in substance use or trigger relapse to substance use.

Public Perceptions of Parents with OUD and Stigma

Opioid use is highly stigmatized^{71,72,73} and a typology of opioid-related stigma was developed to illustrate how it manifests at different levels.⁷⁴ Parents with OUD may encounter structural stigma when seeking services and they may experience internalized stigma when they identify with the negative stereotypes of addiction, plus their family members may experience stigma by association.⁷⁴ Public stigma may motivate parents to hide their opioid use and may justify the secrecy surrounding addiction in families. Many individuals do not understand the biology of addiction whereby the brain changes are dramatic enough to alter behavior, including parental responsibilities, which are often thought to be instinctual. Media coverage of OUD and the opioid use epidemic, including stigmatizing language used, may reinforce public stigma⁷⁵ as well as prevent patients with OUD from seeking treatment. This includes depictions that addiction is a personal choice or a lack of morality, rather than a treatable medical disease.

Early research reported that children of parents with OUD were at significant risk for a variety of complications extending from the prenatal course through preschool.^{76,77} These included prenatal complications (including intrauterine growth retardation),⁷⁸ neonatal withdrawal syndrome (now termed neonatal abstinence syndrome (NAS)),^{79,80} and later impairments in cognition, speech, motor skills, learning, and sleep.^{36,81} Additionally, methadone-maintained mothers were shown to have lower intelligence quotient (IQ) scores and their children were likely “not receiving adequate intellectual stimulation at home.”⁷⁶ These conclusions were based on small convenience samples and did not control for known covariates (e.g., socioeconomic status). This work may have contributed to misconceptions that have been perpetuated about mothers with OUD or those that seek medications for opioid use disorder (MOUD) during their pregnancies. Later studies and a systematic review have shown mixed findings on prenatal exposure to buprenorphine versus methadone regarding neonatal outcomes including the long-term effects of NAS by severity,^{82,83} however, MOUD and behavioral health counseling is the evidence-based treatment approach that is recommended.⁸⁴ Women who enter treatment early can reduce the risk of worse child outcomes by using non-pharmacological interventions, such as kangaroo care, rooming in, skin-to-skin contact, and breastfeeding.⁸⁵ Stigma associated with addiction prevents individuals from seeking treatment and may reinforce feelings of shame and guilt.^{86,87} Stigma causes impacted family members to feel isolated⁵ and unable to benefit from social support, which is critical to resilience.

Services for Families

The SUD prevention and treatment service systems are largely designed to treat individuals²⁵ with limited opportunities for integrated, comprehensive family-based services. The key principles of effective SUD treatment include family services and social services, such as childcare,⁸⁸ which may require a paradigm shift from individual to family-focused services. Given the increased risk of poor child outcomes, evidence-based prevention services may be critical for children impacted by parental OUD. Prevention services for children would include primary prevention of drug use, mental health problems, and behavioral problems. Increasing availability of prescription opioids, including buprenorphine, has been associated with increased reports of child or adolescent exposure to poison control centers⁸⁹ and pediatric hospitalization for opioid poisonings.⁹⁰ The safe use and storage of prescription opioids, including MOUD, is critical to prevent accidental poisoning or diversion. Developmentally appropriate public education campaigns have been tailored for younger children and adolescents. The Centers for Disease Control and Prevention (CDC)’s *Up and Away* campaign addresses this risk by recommending that medications are put away after each use and stored in a safe and locked location with children and adults being educated about the dangers of ingestion.⁹¹

Access to MOUD for parents is critical, not only because it is effective at reducing illicit opioid use⁹² and reducing mortality,⁹³ but because it allows individuals to fulfill their parental role obligations. There is

evidence that MOUD may improve family functioning given that state-level rates of child maltreatment decline with increasing rates of buprenorphine treatment capacity.⁶¹ Only 10.3% of individuals with a SUD in the past year received treatment in 2019,⁹⁴ and mothers may face unique internal and external barriers that prevent them from accessing and engaging in services.⁹⁵ These challenges include fear of removal of a child(ren) from the home, access to childcare, and transportation; as well as guilt and shame regarding the impact of their drug use on their child(ren).^{25,96}

Clinicians may not screen, treat, and/or refer patients for family-based services because of inadequate training, insufficient funding for family-based services, and lack of support. Clinicians may not be using standardized tools to screen for family problems;³⁰ however, some argue that the primary reason is due to lack of clinical time in which to do so.³⁰ Clinicians may be reluctant broaching these topics with parents because it makes them uncomfortable and/or they fear that individuals with SUDs may respond with anger.³⁰ It is unknown the extent to which screening for family needs has been integrated into routine clinical treatment for parents with OUD.

While there is a paucity of family-friendly treatment programs,⁹⁷ several interventions are empirically supported including Brief Strategic Family Therapy, Families Facing the Future, Family Behavior Therapy, Multidimensional Family Therapy, and Multisystemic Therapy.⁹⁸ Families may need integrated comprehensive services such as mental health, trauma-informed care, case management, parenting skills education, social services, legal services, life skills training, job training and childcare.^{9,99} Family needs may vary and hence they should be individualized, as well as reflect the preferences of the parent(s)/caregiver(s) and the child(ren). Most importantly, access to treatment needs to be timely given that family reunification may be contingent upon it.

Collaborative interventions have been developed to improve outcomes for child welfare or court-involved families with SUDs. Family drug courts have been demonstrated to improve outcomes for parents with SUDs and their children.¹² The Sobriety Treatment and Recovery Team (START) Model uses a cross-system collaboration between child welfare agencies, addiction treatment programs, and courts,¹⁰⁰ START has been demonstrated to improve child-parent reunification, particularly among parents that were retained in treatment programs offering MOUD for more than 1 year.^{100,101} Other new collaborative interventions are currently being investigated. For example, the Enhancing Permanency in Children and Families (EPIC) is a collaboration between social work, the juvenile court system, the local health department, and the department of family services.¹⁰² EPIC provides parents with a peer recovery support, and it provides incentives to encourage parents to engage in MOUD, family drug court, and parenting support.¹⁰² Additional research is needed to improve implementation of collaborative family-based interventions to ensure widespread adoption and availability in communities.

Family Reunification and Sustaining Recovery

Family reunification is often contingent upon parental compliance with multiple agencies' requirements and/or regulations which includes participation in drug treatment and/or drug abstinence. A study in California found that among mothers in treatment for a SUD who had lost custody of at least 1 child, less than half (44%) were reunited.¹⁰³ In a more recent study, only 28.8% of children were reunited with their parent(s) within 3 years, and 22% were permanently reunited.¹⁰⁴ Studies have identified several factors that are associated with reunification of families separated due to parental SUDs, and these include demographic characteristics, co-occurring problems, parents' progress in treatment, and services received.^{103,105,106,107,108,109} Other factors associated with reunification are specific drugs being used; child's age; type of placement; caregivers' age, educational level, and mental health problems; and poverty.^{103,105,108} Studies have found that matching parental need and services, such as mental health, housing, and family counseling, may improve the probability of reunification.¹⁰⁹ Parents retained longer in addiction treatment are more likely to be reunified with their children,^{101,110} achieve greater improvements in their parenting skills, and are less likely to engage in drug use.⁵⁷ Parents who maintain or regain custody of their child(ren) have better addiction treatment outcomes compared to those who are separated from their child(ren). For example, a cohort study conducted in Ireland found that parents with OUD, who were caring for their children, had better treatment outcomes at 1 year follow-up compared to parents whose children were removed from their home.¹¹¹

Policy Impact

There is a significant need for effective collaboration between the criminal justice, child welfare, and healthcare systems to improve outcomes for children impacted by parental/caregiver OUD. Individuals with OUD have complex psychosocial, medical, and legal problems that require cross-system collaboration.^{6,12} For individuals who are seeking to initiate treatment or who are early in recovery, accessing services across these systems can be complicated to navigate and even more so for parents. Policies aimed at reducing non-medical use of prescription opioids in adults rarely consider the impact or have empiric data regarding the effect on children. Public education campaigns and other interventions to improve the safe storage and use of prescription opioids are promising; however, there is insufficient evidence on the efficacy of these strategies to reduce opioid-related harm in adults and youth.¹¹² Further, existing evidence suggests that few adults routinely engage in safe use and storage of prescription opioids.¹¹³ There are currently efforts underway to teach children and adolescents how to respond to an overdose.¹¹⁴ The Family First Prevention Services Act was enacted in 2018 to reform the child welfare system and to improve access to services for families with behavioral problems. This federal policy provided funding for childcare when parents are in residential treatment and for kinship navigator programs.¹¹⁵ It also allows foster care candidates to access Title IV-E funds, which were previously restricted to only those already in the foster care system, and programs are required to use trauma-informed services.

Families impacted by parental OUD often struggle with social, economic, and legal problems that can undermine parents' ability to achieve long-term recovery or achieve permanent reunification with their children.¹ These complex issues require multifaceted interventions and require alignment of service delivery and outcomes. Radel and colleagues (2018)⁹⁹ note the need for multisystem agreement on parental progress toward recovery and for increasing the timeliness of family reunification or permanent placement. In practice, this occurs infrequently, and lack of alignment can have devastating consequences for families. For example, some courts may require complete abstinence from opioids, including MOUD, before reunifying families.¹⁰¹ Yet research suggests that only 6.6% of individuals may be able to achieve long-term recovery without MOUD.¹¹⁶ Federal policies should be expanded to encourage alignment of service delivery goals across systems and tie financial reimbursement to empirically-supported services.

Evidence-based Clinical Recommendations

Clinicians can improve how they deliver services for parents with OUD by better understanding their unique needs, recognizing how shame and stigma may impede recovery, and by providing referrals to integrated family services to help parents sustain recovery. It is critical for clinicians to use patient-centered, person first language and to avoid stigmatizing language.^{87,117} Clinical improvements may be slow, and patience is required to achieve cross-system collaboration.²⁵ As parents work toward recovery, they will undoubtedly encounter stressful situations that challenge their resolve, and stigma may quietly undermine their self-efficacy needed to achieve their goal. Below outlines clinical strategies that can be used by clinicians.

1. *Educate parents on safe storage and disposal of prescription opioids.* Clinicians should regularly remind patients of the importance of securely storing their opioid medications, including MOUD. While this is valuable for parents, it is also important for all patients who may have children or adolescents visiting their home. Education on the safe use of prescription opioids should be evidence-based and developmentally appropriate.
2. *Screening parents for at-risk opioid use/OUD and the potential impact on their child(ren).* Early identification of at-risk opioid use can be critical to preventing the onset of addiction and validated tools are available.¹¹⁸
3. *Ask children and adolescents about parental/caregiver hazardous opioid use/addiction.* Developmentally appropriate screening tools and brief interventions are available to help clinicians talk about drug use in the home.^{30,119} Clinicians can be a trusted adult that can help children understand how addiction can change their parent(s)/caregiver(s) behavior and can be vital to helping children access support services.
4. *Assess need for naloxone in the home and train children/youth.* It may be beneficial to universally co-prescribe naloxone when opioids are prescribed and provide overdose prevention education. Younger children can be educated, more broadly, about how to get help when an adult has a medical emergency. Children whose parents are actively using opioids and/or in recovery from an OUD should be educated on how to identify the signs and symptoms of an opioid overdose, as well as how to obtain and administer naloxone.
5. *Make referrals to family-based and other social services.* Validated instruments can be used to easily identify family needs and clinicians should have a comprehensive list of family services in their community to facilitate referrals as needed.
6. *Trauma-informed care for women with OUD.* Research suggests that individuals with a history of sexual or physical abuse may have worse addiction treatment outcomes.¹²⁰ Trauma may also be a trigger for relapse among women.^{121,122} More information on trauma-informed services is available elsewhere.⁴⁵

Other resources for clinicians are available through the Title IV-E Prevention Services Clearinghouse and more information on family-based treatment is available at SAMHSA (SUD Treatment and Family Therapy: Treatment Improvement Protocol).

Brief Case Example

To illustrate the impact of OUD on families and children, the following section is a case report of a 34-year-old mother (“Christy”) who was diagnosed with an OUD and anxiety disorder. This case adeptly conveys the compounding effects of addiction/relapse, changes in child custody, traumatic events, and stigma. It illustrates how uncoordinated systems exacerbate family’s emotional health difficulties and negatively impact reunification. The names have been changed to protect the identity and anonymity of the family.

Christy began to use illicit substances, first hallucinogens soon followed by opioids, when she was 16 years old; 1 year later, she became pregnant with her first child (“Brittany”). Christy recalled being thrilled to discover that she was pregnant even though it was unplanned. She found it easy to refrain from drug use during her pregnancy. Christy received prenatal care in her first trimester of pregnancy and throughout treatment. After delivery, Christy’s OBGYN prescribed opioids to treat pain caused by ovarian cancer that was diagnosed when she was 16 years old. She reported getting “hooked” on prescription opioids faster than she had cigarettes; she quickly began healthy use of the opioids prescribed to her, and subsequently her anxiety increased. Christy was able to get her primary care physician to prescribe a benzodiazepine to treat her anxiety. Christy recalled how easy it was to manipulate her symptoms to ensure that clinicians would prescribe the medications she desired. Soon after, she began “doctor shopping” to obtain medications for her own use, as well as a surplus that could be sold to generate income. Many years later during therapy, Christy recalled how she regretted that her daughter witnessed her drug use and intoxication. To compensate for her deficiencies as a parent, Christy used the money that she earned from selling drugs to purchase her daughter expensive gifts.

During the time of her active use, Christy recognized that her daughter would be safer if she lived with her grandmother. Brittany’s biological father also struggled with substance use, and he was incarcerated during the majority of her childhood for committing a violent crime. He did not have contact with Brittany or Christy after his incarceration. Christy also was arrested and subsequently incarcerated for drug distribution. Brittany’s grandmother was awarded temporary custody in an attempt to avoid child welfare involvement. While incarcerated, Christy did not receive addiction treatment, and she found herself ruminating on her parental failures. Christy, wanting to protect Brittany, decided not to see Brittany during her 3-year incarceration, which worsened Christy’s loneliness, guilt, and shame. Following her incarceration, Christy resided in a halfway house. She became romantically involved with a partner who was also in recovery, and she attempted to rebuild her relationship with Brittany who was now 12 years old. Christy’s partner was able to quickly bond with Brittany, while it was not so easy for Christy to rebuild trust and her relationship with her daughter.

Christy struggled to manage her own emotions and recovery, her current romantic relationship, and to rebuild her relationship with Brittany. Unfortunately, her romantic partner relapsed after 1 month, and Christy relapsed 2 months after that, which was a violation of her parole conditions. She was remanded to prison. Christy described feeling powerless over her addiction at this time, and while she knew that recovery meant changing the people you are around, the places you go, and the things you do, this was not so easy in her small rural community. When she was released after 6 months, Brittany refused to live with Christy, who then rapidly clinically deteriorated over the subsequent weeks as she was not able to manage her feelings of rejection. In addition, she could not obtain gainful employment having had a felony conviction. Christy was continuously plagued by deep feelings of guilt regarding her inability to protect Brittany from her drug use and her partners’ drug use. Her feelings of hopeless, isolation, and inability to effectively rebuild her life culminated in a heroin overdose witnessed by her daughter. This was traumatic for Brittany as it took extensive CPR by EMS to revive Christy. Soon after this time, an acquaintance encouraged Christy to use methamphetamine to avoid feeling the “low” from heroin, and Christy thought to would help with opioid withdrawal. Her romantic partner also began to use methamphetamine and experienced

methamphetamine-induced psychosis which caused him to hallucinate and made him paranoid, only adding to the chaos. Four months after Christy started using methamphetamine, she was reincarcerated for 56 days on drug charges, and her romantic partner was murdered. This was a significant loss for Christy and her daughter.

Christy recommitted to rebuilding her family upon release from prison, and her new romantic partner, who was also in recovery, was able to be a healthy support for her. After a short time, Christy became pregnant with her second child (“Manny”), and she was able to find a job, but she began using drugs again with a co-worker. Brittany, who was 16 years old at that time, was living with Christy and, given her pregnancy and desire to maintain her family, Christy entered a buprenorphine treatment program. Upon delivery of Manny, CPS visited Christy in the hospital. Christy shared with the CPS worker and the hospital clinicians that she was using prescribed buprenorphine in her addiction treatment program; she was shocked at the stigma she encountered and how she was dismissed for being an “addict.” CPS conducted a 3-month home evaluation and determined that Christy was guilty of abuse and neglect of 2 minors because she had used buprenorphine during her pregnancy. Her children were removed by CPS from the home, and she was devastated that her treatment was perceived as “replacing one drug with another.” Fortunately, she was supported by the staff at the buprenorphine treatment program, and her romantic partner was able to support her during this time and serve as a parental figure for their children. Her CPS case was eventually dropped after she complied with her CPS visits, and completed parenting classes and her parole obligations. Christy thought the nightmare was over, but the CPS case was re-opened because her partner had previously lost custody of a daughter he never knew existed while he was in prison. CPS would not allow Manny’s father to be around the baby due to his history, so Christy’s family was separated yet again, and she was left alone to find employment while trying to sustain her recovery and fulfill her parental responsibilities.

Brittany began to trust her mother more, as she saw how hard Christy was working to maintain her sobriety and build a home for her and her brother. At the same time, they were both aware of the regret and resentment that Brittany had as Christy was not able to do that for her when she was young. Christy noticed that her daughter seemed to be depressed, and she wanted to quickly get Brittany into mental health treatment; however, such services were not easily available in her community. Christy took her daughter to her own therapy sessions, and together they were able to find an opening sooner. Through therapy, their ability to communicate improved, and they became even closer. Three months later, Christy was called in for a CPS mandated drug screen. Christy vividly recalls the “blood stick” was handled by many staff members that day, and it was not sanitary. Helpless, she could only watch as this occurred, and she was not allowed to wash her own hands. She was disgusted by the entire procedure. Her serum drug screen was positive for heroin and fentanyl, which, according to her, she had not used for over 8 months. Brittany and Manny were removed from her home by CPS with court approval even though the positive drug screen was never sent for confirmatory testing. This situation occurred when state-mandated quarantines were in place due to the COVID-19 pandemic, and Christy could not reach anyone to be re-tested. The buprenorphine program that treated Christy was able to do a drug screen that was negative for everything except her prescribed medication. Unfortunately, CPS would not accept the drug screening result conducted by Christy’s addiction treatment program. Brittany began to advocate for her mother, as she saw her struggling and she had witnessed her mother’s progress. Finally, CPS agreed to allow supervised visits as they placed the children with Christy’s mother, the children’s grandmother.

Christy had to fight to regain custody of her children while participating in parenting classes during a pandemic with a multi-disciplinary collaborative team. Christy successfully petitioned the court and was reunited with her children 2 months later. She is working now to mend and repair her relationships with her children and their resultant anxiety from their separation. Christy remained sober during the significant stressors that had previously triggered relapse with the support of her treatment team and family. Manny’s

father relapsed, and without insurance, finding treatment access was a challenge. Christy has maintained appropriate boundaries and has continued to work to preserve her family unit. She knew from past experiences that change had to start with herself. She has prioritized her physical health, mental health, and sobriety before taking care of others. Through this, she had successfully completed a Peer Recovery Coach certification; however, due to her criminal history and stigma, she has found it difficult to obtain employment.

Conclusions

The true impact of the opioid epidemic on children and families is only just beginning to be realized, and it will undoubtedly have lasting effects in those communities disproportionately impacted by overdose deaths. While genetics partially predicts the onset of an OUD, environment seems to be more important in shaping the impact of parental OUD on children.^{57,65} These effects range from poor parenting with minimal effect on child development to child abuse. Even when parental drug use results in a formal investigation of child maltreatment, the vast majority of cases involve neglect and infrequently physical or sexual abuse. Parental drug use itself is defined as 1 component of adverse childhood events and family dynamics may be dysfunctional, but parental drug use should not be synonymous with child maltreatment. Mothers may engage in strategies to protect their children from the harmful effects of their drug use, and non-drug using family members may foster resilience in children. The cyclical nature of addiction is an emotional roller coaster for children and their kinship networks. There are unpredictable periods of abstinence and relapse that may lead to separation and reunification of parents and their children. Parents seeking recovery struggle with guilt and shame about how their drug use impacted their children; they encounter significant stigma and barriers to receiving comprehensive integrated services and misalignment of cross-system goals may prevent timely reunification of families. Ultimately, integration of evidence-based comprehensive family services and trauma-informed care is vital to helping parents achieve long-term recovery and to stop the intergeneration transmission of OUD.

Key Points Summary

- Despite the magnitude and longevity of the opioid crisis, there is very little known about on how it impacts children and families.
- Parents with OUD often have parenting deficits that increase the risk of child maltreatment and may increase the risk of drug use and behavioral problems in their children.
- Formal investigations of child maltreatment, mostly involving neglect, may result in children being temporarily or permanently removed from the home.
- Evidence-based integrated comprehensive family services are essential to helping parents achieve long-term recovery and to reducing the risk of mental health and behavioral disorders in their children.

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