Practice and Policy Considerations for Parents With Opioid Use Disorders

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Abstract
Parental substance use disorders negatively impact a child's development both prenatally and postnatally. Caregivers struggling with substance use disorders, and Opioid Use Disorder in particular, often have difficulty accessing appropriate holistic clinical interventions and are at high risk of losing custody of their children due to abuse and neglect issues. Treatment interventions that attend to the caregivers' substance use disorders, mental health symptoms, and parenting needs are essential. Moreover, system collaboration among medical, mental health, substance use, corrections, and child protection providers is required to optimally address the parenting needs of caregivers with substance use issues to maximize treatment outcomes and enhance their children's overall development.

Decades of research in developmental science have demonstrated the important role of relationships in early social–emotional development and lifelong trajectories of health and well-being (Lupien, McEwen, Gunnar, & Heim, 2009; Shonkoff, Garner et al., 2012; Sroufe, Egeland, Carlson, & Collins, 2005). Critical to adaptive early relationship experience is the child's experience of stable, sensitive, responsive care. In this article, we will review the role of relationships in early childhood, the crisis and impact of substance abuse (especially opioid use), on child and family functioning, practice, and policy implications.

Role of Relationships in Early Development

A prolonged period of helplessness in human infancy permits flexibility in brain development, but also means that infants rely heavily on the caregiving environment. Although human infants exhibit impressive capacities, they are not able to regulate their own arousal or emotional states apart from the caregiving context. Self-regulatory capacities and forms of dysregulation evolve over the early childhood period through a dyadic process, initially orchestrated by the caregiver (e.g., Brazelton, Koslowski, & Main, 1974; Sander, 1975; Sroufe, 1996; Stern, 1985). An adaptive early relationship experience and the development of self-regulation require caregiver commitment to the child and the ability to create a safe, stable caregiving environment. The caregiver must learn to attend to, interpret, and respond appropriately to infant signals and to effectively engage the infant and young child in sustained, organized interaction (Ainsworth, Blehar, Waters, & Wall, 1978).

The inability of some caregivers to adequately care for young children may derive from multiple sources, including parental histories of adversity such as trauma, maltreatment, mental illness, and substance use disorders (e.g., Cort, Toth, Cerulli, & Rogosch, 2011; Courtois & Ford, 2013; Goodman & Brand, 2009; Suchman, DeCoste, Leigh, & Borelli, 2010) as well as

current circumstances such as poverty, life stress, and the lack of social support (Jackson, Preston, & Thomas, 2013; Knitzer & Perry, 2009; Sroufe et al., 2005). Past and present adverse experiences may contribute to the inability of caregivers to understand and attend to a child's needs, wishes, and intentions apart from their own and to consider the influence of their own mental states and behavior on their children (i.e., the ability to reflect on experience; Grienenberger, Kelly, & Slade, 2005; Slade, 2005; Suchman et al., 2010).

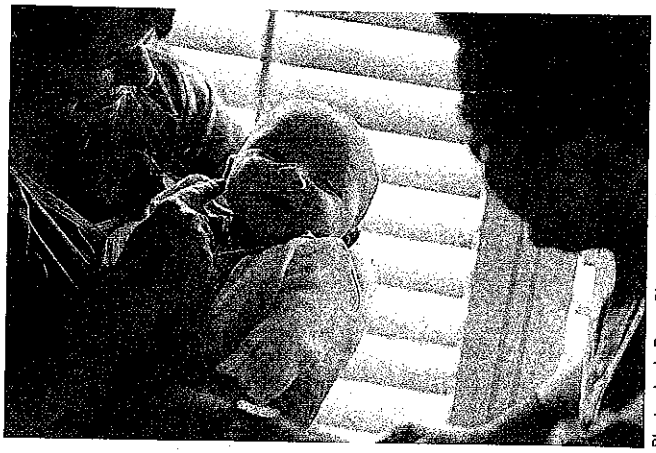
Impact of Substance Use Disorders on Parenting

Family life for children with one or both parents who abuse drugs or alcohol often can be chaotic and unpredictable. Children's basic needs—including nutrition, supervision, and nurturing—may go unmet, which can result in neglect. These families often experience a number of other challenges—such as mental illness, domestic violence, unemployment, and housing instability—that also affect parenting and contribute to high levels of stress (Hopping-Win, 2012). A parent with a substance abuse disorder may be unable to regulate stress and other emotions, which can lead to impulsive and reactive behavior that may escalate to physical abuse (Chaplin & Sinha, 2013).

The effects of parental substance use disorders on a child can begin before the child is born. Maternal drug and alcohol use during pregnancy have been associated with premature birth; low birth weight; slowed growth; and a variety of long-term physical, emotional, behavioral, and cognitive problems (Hopping-Winn, 2012). Research suggests powerful effects of legal drugs, such as tobacco and alcohol, as well as illegal drugs on prenatal and early childhood development (Behnke & Smith, 2013; Jacobson & Jacobson, 2003).

Postnatally, mothers with chemical dependency issues may struggle to respond to their infants' cues in a sensitive, consistent manner. In particular, they may have difficulty responding appropriately to infant distress and supporting infant social–emotional and cognitive development through guidance and exploration (Suchman et al., 2010). Concurrent low levels of maternal reflective functioning may impact caregiver sensitivity (Pajulo et al., 2009; Suchman et al., 2010). As a result, many mothers struggling with chemical dependency lose custody of their children to child welfare for neglect (Minnesota Department of Human Services, 2009; Suchman et al., 2010).

Locke and Newcomb (2004) investigated the relationship between a person's experience of childhood abuse and exposure to parental substance use and their own polydrug use and poor parenting practices as adults. The authors found a direct correlation between history of childhood abuse and poor parenting as an adult, as well as exposure to parental drug abuse as a child and polydrug use as an adult. Polydrug use as an adult also predicted poor parenting (Locke & Newcomb). The study highlighted the complex relations between childhood experiences, the development of psychopathology (as indicated by polydrug abuse), and parenting behaviors.



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Unfortunately, much of the literature on the impact of drug use on parenting focuses on mothers, with little research attention to the impact of parenting by fathers with substance use disorders (McMahon, 2013). Moreover, only a few substance use treatment programs designed for men focus on fathering (McMahon). The limited research suggests the need for gender-specific programming for fathers with substance use disorders as both substance use and parenting practices may differ for men and women (McMahon).

The Crisis of Opioid Use Disorder

Although researchers have been studying the impact of substance use disorders on parenting for decades, attention has recently focused on Opioid Use Disorder (OUD) due to significant increases in use and related deaths in the past 10 years (Rudd, Seth, David, & Scholl, 2016). Currently, the majority of drug overdose deaths (66%) involve an opioid. (In 2016, the number of overdose deaths involving opioids, including prescription opioids and heroin, was 5 times higher than in 1999; Rudd et al., 2016.) The rate of opioid use in pregnancy rose 127% between 1998 and 2011 (Maeda et al., 2014). This same study found a significantly higher rate of in-hospitalization death of these mothers, as well as higher rates of cesarean births and preterm births when compared to mothers with no opioid substance use disorders.

Nationally, Desai, Hernandez-Diaz, Bateman, and Huybrechts (2014) found that almost 22% of pregnant Medicaid beneficiaries filled a prescription for an opioid during their pregnancy. Similarly, the Minnesota Opioid Treatment Program Central Registry (2018) found that substance use disorder treatment admission for women who reported being pregnant at time of admission increased 101.7 % between 2007 and 2016.

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The increase in opioid use of pregnant women has coincided with an increase in child protection involvement for families with substance use disorders. In 2016, leading issues related to child protection involvement for young children and their families were substance use disorders and the caregiving neglect surrounding that use (Minnesota Department of Human Services, 2016). The leading issue related to foster care placement of young children in the state of Minnesota is parental drug or alcohol abuse (30%); the second leading cause is allegations of neglect (25%), often related to parental substance abuse (Minnesota Department of Human Services).

Distinctions Between OUD and Other Substance Use Disorders

OUD is framed and treated differently than other Substance Use Disorder (SUD) in a number of ways. OUD is a broad term that encompasses a unique blend of legal substances (analgesic medications), illegal substances (e.g., heroin), illegal use of legal substances (using a medication that was dispensed to someone else), and migration from one to another (with initial opioid use for a medical condition followed by increases in potency and volume of use and a transition to heroin). Opioids as a group of substances represent the largest range of potency, duration, and availability of substances related to treatment admission in Minnesota (Moldenhauer, 2017).

Impact of OUD During Pregnancy

A basic rule of obstetrics is "what happens to mom, happens to baby." Developing fetuses are significantly affected by maternal opioid consumption. Many factors, including maternal stress, maternal behavior (e.g., malnutrition), or the use of a drug (or a metabolite of it) that crosses the placental barrier, can negatively affect normal fetal development (Frenz, 2015; Hudak & Tan, 1998).

Following birth, there may be a window of neonatal abstinence syndrome (NAS). With consistent in-utero exposure, the fetus develops tolerance to the opioid. At delivery, the physical connection is severed, leading to the infant's withdrawal from the substances or death (Hudak & Tan, 1998). While the withdrawal symptoms in the infant will abate with intervention and time, continued parental use and associated behavior may continue to delay or negatively impact development due to the lack of caretaking and the lack of the scaffolding of speech and motor skills and adaptive learning (Fill, Carey, & Grosso, 2017)

Considerations for Treatment of OUD in Pregnant Women

Pregnant women are a priority for admission to SUD treatment programs under federal law found in 45 CFR 96.131. However, programs hesitate to admit pregnant women to out-patient and residential services because of liability and legal concerns regarding drug-related pregnancy complications. In addition, access to services is challenging, as most opioid treatment programs have limited availability (Minnesota Opioid Treatment Program Central Registry, 2018). For regions with few SUD residential treatment programs, a promising practice encourages parents to bring their young children to stay with them during SUD treatment (Moldenhauer, 2017). See specific postnatal parenting interventions in the next section.

The literature suggests the best option for pregnant women with an active OUD is medication-assisted therapy, specifically methadone or buprenorphine products (American College of Obstetricians and Gynecologists, 2016). However, Jones et al. (2010) found that the type of medication-assisted therapy provided had significantly different impacts on the developing fetus. In fact, they found that pregnant mothers treated with buprenorphine gave birth to babies with less severe NAS symptoms and required less morphine treatment than methadone-exposed fetuses. In addition, Kaltenbach and colleagues (2012) found that cigarette smoking, SSRI (antidepressant medication) intake, and low maternal weight increased NAS in children at birth.

It is important to note that treatment of the SUD alone may not be sufficient in supporting caregivers in treatment completion. Benningfield and colleagues (2012) reported that pregnant women with opioid substance abuse issues and anxiety symptoms dropped out of treatment at significantly (4.6 times) higher rates than pregnant women with no symptoms and at significantly higher rates than women with depressive symptoms only. Thus, opioid use and anxiety symptoms must be addressed simultaneously. Access to appropriate SUD treatment paired with treatment of co-occurring mental health disorders is critical for completion of SUD programs and for the developing fetus. Also, Norman et al., (2008) found that SUD clients reported that the inclusion of peer support specialists (staff with a history of lived substance use disorders) in their treatment prevented the clients from leaving treatment prematurely.

Promising Parenting Interventions for Parents With OUD

As noted, parents with SUDs struggle to attend to and understand the cues of their children separate from their own needs and thus struggle to provide responsive caregiving. These challenges often lead to neglect or abuse of the infant and young child (Chaplin & Sinha, 2013). A program that has successfully addressed some of these issues is Mothering From the Inside Out (MIO; Suchman et al., 2010; Suchman & DeCoste, this issue, p. 17). In a randomized clinical trial (Suchman et al., 2017), MIO mothers exhibited increased capacity for reflective functioning and representational coherence initially following treatment and at 3 months post treatment. At 12 months post treatment, mothers demonstrated greater parenting sensitivity. For those mothers experiencing increased addiction severity, MIO served as a protective factor for maternal reflective functioning and quality of mother–child interactions.

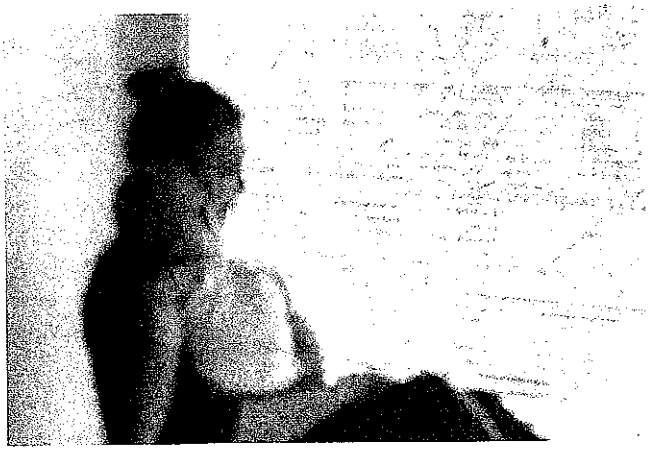
McMahon (2013) has developed a promising parenting intervention for fathers with opioid addiction called *Fathers Too!* The intervention targets fathers enrolled in methadone maintenance treatment. The intervention addresses the fathers' secondary substance use, parenting goals, and childhood adversity histories through individual psychotherapy provided in 16–20 clinical sessions. The efficacy of the intervention is currently under review.

While not specific to substance use disorders, literature focusing on parenting interventions with mothers who struggle with serious mental illness recommend that clinicians use video recording of parent–child interactions and video feedback as a method of assisting the caregiver to attend to her own caregiving behaviors as well as the child's reactions (Wan, Moulton, & Abel, 2008). Interventions using only clinician modeling of sensitive caregiving or discussing sensitive caregiving have not proven effective in changing parenting behaviors of mothers with serious mental illness (Wan et al.).

Similarly, in a meta-analysis of 81 studies focusing on enhancing sensitive caregiving, parental reflective functioning, and/or parental support in parents of young children (Bakermans-Kranenburg, van IJzendoorn, & Juffer, 2003), the most effective interventions targeted parenting sensitivity through behavioral interventions, used video feedback, included 16 sessions or less, and were aimed at clinical samples (either parents with mental illness or children with mental health concerns). Despite a small sample (3 studies), interventions that included fathers were more effective than interventions including mothers only.

Two parenting interventions that include components of video feedback, behavioral coaching targeting sensitive care, and reflection on the parent–child interaction include:

1. Attachment Biobehavioral Catch-up (Bernard, Meade, & Dozier, 2013; Bick & Dozier, 2013), a 10-week intervention for infants and their parents, and



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2. Video-feedback Intervention to Promote Positive Parenting-Sensitive Discipline (Bakermans-Kraneburg, van IJzendoorn, Mesman, Alink, & Juffer, 2008), a 4- to 8-week intervention for children under 3 years old and their parents.

System Interventions for OUD

To meet the complex needs of parents with substance use disorders, systems must be aligned to holistically support the caregivers and their children. Communication and active collaboration across systems help ensure that parents in need of substance abuse treatment are identified and receive appropriate treatment in a timely manner, while children's intervention needs are also addressed (United States Government Accountability Office, 2017).

When collaboration does not occur, systems may inadvertently negatively impact treatment access for caregivers with substance use disorders. For example, according to a report presented to the Minnesota Department of Corrections, some probation/parole officers view medication-assisted therapy as not being "clean" or "off the dope" and in some cases it is used as leverage related to child custody/placement and even a termination of parental rights (Moldenhauer, 2017).

In contrast, collaborative and integrated strategies have shown promising results with women remaining in treatment longer, being more likely to reduce substance use, and being more likely to remain or reunite with their children (Marsh & Smith, 2011). Other cross-system changes recommended by the Child Welfare Information Gateway (2014) include:

1. cross-training of child welfare, substance abuse treatment professionals, and infant mental health providers such as home visiting programs to build an understanding of each other's systems, legal requirements (e.g., Adoption and Safe Families Act [ASFA]),

goals, approaches, and shared interests, such as the importance of the parent–child relationship for social–emotional development of the child and the importance of multigenerational mental health);

2. co-location of substance abuse specialists in child welfare offices to assess and engage parents, provide services to families, and offer training and consultation services to child welfare workers;
3. cross-system partnerships based on shared principles that ensure coordinated services through formal linkages (e.g., interagency agreements) between child welfare, treatment, and other community agencies;
4. cross-system information sharing related to screening and assessment results, case plans, treatment plans, and progress toward goals, which can support professionals in each system to make informed decisions, while still adhering to confidentiality parameters;
5. joint planning and case management to help safeguard against parents becoming overwhelmed by multiple and potentially conflicting requirements of different systems;
6. wraparound and comprehensive community services that address multiple service needs of parents and children, including those related to parenting skills, mental health, health, domestic violence, housing, employment, income support, education, and child care;
7. flexible financing strategies that leverage or combine various funding streams to address the needs of substance abuse treatment for families involved in child welfare; and
8. linked data systems that track progress toward shared system objectives and achievement of desired outcomes while also promoting shared accountability. (p. 8)

Policy Changes to Better Support Parents With OUD

Policies that support multigenerational interventions promote the development of residential substance use treatment facilities where children remain with caregivers and caregivers receive evidenced-based parenting programs (ATTC Center of Excellence on Behavioral Health for Pregnant and Postpartum Women and Their Families, 2017). Outside of the United States, such integrative programs show positive outcomes for both caregivers and their children (Pajulo et al., 2012). In addition, policies that support the development of specialized court teams encourage the treatment rather than criminalization of SUD (Marlowe & Carey, 2012).

Finally, while parental substance abuse continues to be a major challenge in child welfare and corrections, the past two decades have witnessed new and more effective approaches and policies to address the multifaceted issues of substance-using caregivers. The Child Welfare Information Gateway (2014) proposed the following recommendations:

1. promotion of protective factors, such as social connections, concrete supports, and parenting knowledge, to support families and buffer risks;
2. early identification of at-risk families in substance abuse treatment programs and through expanded prenatal screening initiatives so that prevention services can be provided to promote child safety and well-being in the home;
3. priority and timely access to substance abuse treatment slots for mothers involved in the child welfare system;
4. gender-sensitive treatment and support services that respond to the specific needs, characteristics, and co-occurring issues of women or men who have substance use disorders;
5. family-centered treatment services, including inpatient treatment for mothers in facilities where they can have their children with them and programs that provide services to each family member;
6. recovery coaches or mentoring of parents to support treatment, recovery, and parenting; and
7. shared family care in which a family experiencing parental substance use and child maltreatment is placed with a host family for support and mentoring. (p. 6)

Summary

Parents experiencing substance use (especially opioid use) disorders are often challenged to provide stable caregiving environments and sensitive care to their children. In order to address the OUD crisis in the United States for pregnant women and parents of young children, programming must focus not only on caregiver recovery, but underlying adult mental health issues, the impact of prenatal opioid use on the fetus and young child, and the systems serving these families including child welfare and corrections. Programming must be integrated (or coordinated) and multigenerational to ensure that both caregiver and child development are supported, and policies must allow for system collaboration to address the multifaceted issues faced by families struggling with substance use disorders.

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