National Council on Family Relations

Juggling Child Protection and the Opioid Epidemic: Lessons from Family Impact Seminars

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- **The opioid epidemic, involving opioid misuse and addiction, has had substantial implications for the welfare of children and families in the United States and for state service providers and public health and safety.**
- **Children in the United States are suffering as a result of the opioid epidemic: They are experiencing maltreatment from**

parents/ caregivers, then entering foster care, and subsequently losing caregivers to fatal overdoses at unprecedented rates.

- **Promoting sustained family well-being and child safety requires investment in policies and programs that increase early detection of substance use among expectant parents, provide holistic long-term treatment options to parents with substance use disorders, and utilize a "two-generation" approach to treatment.**

Abstract

Over the past decade, the number of children in the U.S. child welfare system has steadily increased, alongside rising opioid misuse and associated deaths. This brief presents the intertwined landscapes of opioid misuse and child and family welfare in three geographically different states—Indiana, Massachusetts, and North Carolina. State-level policy responses to the opioid epidemic and the associated impacts of it on children and families should invest in two-generation approaches to substance use disorder (SUD) prevention and treatment, optimize early detection and safe treatment of SUD among pregnant women, and expand access to medication-assisted treatment for individuals struggling with opioid abuse, including parents in the child welfare system.

Introduction

The number of children under the supervision of state child welfare systems nationwide has climbed to record highs. For example, the number of children served by foster care (i.e., out-of-home care) increased by nearly 50,000, from 638,041 in 2013 to 687,345 in 2018.[1] The rate of child removals attributable primarily to parental substance use doubled from 18.5% in 2000 to 36% in 2018,[1] which has changed the composition of American families, and challenged state systems to simultaneously combat an addiction crisis (i.e., primarily opioid misuse) while protecting affected children and families. This policy brief provides an overview of recent issues at the intersection of opioid misuse and child protection in the United States through three case studies. These case studies outline specific needs of and policy strategies pursued by states in three different regions—Indiana (Midwest), Massachusetts

(Northeast), and North Carolina (South East)—around issues related to substance misuse and to child and family welfare.

> "While the misuse of drugs has always been part of the constellation of issues affecting parenting in families involved in the child welfare system, the current crisis has affected communities more broadly than past epidemics have. Child welfare agencies in many parts of the country are struggling to respond."[2]

In recent years, the opioid epidemic has largely dominated the national conversation around substance misuse and its effects on communities. The U.S. Department of Health and Human Services estimated for 2017 that 11.4 million Americans misused prescription opioids and another 886,000 used illicit opioids (e.g., heroin), including 81,000 of whom used those substances for the first time.[3] According to the National Institute on Drug Abuse, in 2017 an estimated 1.7 million Americans had substance use disorders (SUDs) related to prescription opioids and more than 650,000 related to illicit opioids.[4] Furthermore, since 1979, the United States has seen a 22-fold increase in opioid-related mortality;[5] and in 2017, nearly 68% of the 70,200 overdose deaths involved opioids, prompting a federal declaration of the opioid crisis as a public health emergency.[6]

The consequences of the opioid epidemic reverberate through families in the United States, as many of the nearly 12 million adults misusing opioids are parents.[7] For instance, foster care placements and permanent terminations of parental rights have risen parallel to trends in opioid misuse, indicating that parents are struggling to meet child welfare system requirements for being reunited with their children.[1] Between 2000 and 2016, the prevalence of parental substance use as a factor in child removals by U.S. child welfare authorities almost doubled (from 18.5% to 35.3%),[8] and parental substance use has become the second most common circumstance

associated with child removal (accounting for 36% of removals in 2017). The most frequent circumstance is neglect (62%), which is routinely comorbid with parental substance use.[9] One example of the intergenerational risks associated with parental substance misuse: nearly 6,300 youth removed from their homes in 2017 were misusing substances themselves.[10] State child welfare systems have been forced to address this collateral damage of the opioid epidemic and have seen child welfare caseloads increase throughout the epidemic.[2]

While these national-level statistics are informative regarding the general landscape of the opioid epidemic and child welfare trends, analyses at the state level may be more useful for policymakers, as child protection systems are orchestrated differently within each state, and because the opioid epidemic has differentially affected regions of the United States. Here, we provide brief glimpses into three U.S. states in different regions—Indiana (Midwest), Massachusetts (Northeast), and North Carolina (Southeast)—as well as strategies pursued by each state to address these complex issues.

Family Impact Seminars

Indiana, Massachusetts, and North Carolina were selected as examples to be highlighted in this brief because they represent regions of the United States facing slightly different manifestations of the opioid epidemic and because each state focused on the epidemic in state Family Impact Seminars in recent years. In the same way that policymakers consider the economic impact of pressing issues and policies, Family Impact Seminars encourage policymakers to consider the impact of issues and policies on families (i.e., to use a "family impact lens"). Below, we summarize the issues in these three states, which have recently dedicated Family Impact Seminars to these issues, and provide a brief overview of the related state-level legislative landscape.

What Are Family Impact Seminars?

Family Impact Seminars are a series of presentations, discussion sessions, and briefing reports that bring nonpartisan, solution-oriented research on family issues to state-level policymakers (e.g., legislators, legislative staffers, state agency leadership). More than 20 states regularly hold or have held seminars, which are usually hosted at the state capitol and include presentations by experts, a Q&A from lawmakers, and a written report produced after the seminar. To learn more about Family Impact Seminars, including how to bring them to your state, and to review materials from past seminars, visit the Family Impact Institute website.[11]

Key Components of a Family Impact Lens in Policymaking

- Analyzing potential consequences of any policy or program for family well-being
- Exploring how families are used as a means to accomplish other policy ends (e.g., workplace policy promotes employee productivity by providing on-site childcare)
- Determining when families act as access points to public policy– related benefits (e.g., immigration, survivor benefits, Earned Income Tax Credit) by assessing eligibility and distribution of benefits to individuals.

Recent Family Impact Seminars on Related Topics

Indiana	Massachusetts	North Carolina
2018: "Our Double Epidemic: Hoosier Children Caught in the Opioid Crisis"	2015: "Mission Critical: Reforming Foster Care and Child Protective Services"	2016: "Intersections of Child Welfare and Substance Abuse: Strategies for Supporting Families"

Indiana	Massachusetts	North Carolina
2015: "Rising Substance Abuse and Hoosier Families: What Can Legislators Do?"	2016: "Chemical Reactions: Marijuana, Opioids, and Our Families"	

Indiana

Opioid Misuse

Opioid-related overdose deaths in Indiana surged by 271% between 2010 and 2016, with opioids involved in 92% of all known overdose deaths in 2016.[12] By 2017, Indiana reported their third-highest single-year increase in overdose-related deaths, with an 18% increase over 2016.[13] Nearly 30% of all opioid-related deaths involved individuals age 30–39, many of whom left behind young children.[13] Furthermore, nearly 15% of infants born in Indiana in 2017 were exposed prenatally to opioids, which exceeds the national average of 11%.[14]

Child and Family Welfare

Indiana has seen one of the sharpest increases in the number of children in foster care since the beginning of the opioid epidemic.[2] In 2017, Indiana's Department of Child Services reported 20,394 children in out-ofhome placements, up 89.4% from 2005.[15] More than half of all child removals in Indiana in 2017 were linked to parental substance use,[15] far higher than the national average of 35%.[8] Indeed, substantiated incidents of child maltreatment associated with caregiver substance use increased in Indiana from 4,961 in 2015 to 7,158 in 2017, when 25% of children who experienced child maltreatment had a caregiver with SUD.[16] Also in 2017, Indiana's governor commissioned an independent audit of the Department of Child Services; the audit resulted in recommendations to expand treatment and resources for families

struggling with SUD, and to expand interventions based on the Sobriety Treatment and Recovery Teams (START) model, an intensive SUD-specific intervention for child welfare–involved families that incorporates peer recovery coaches and medication-assisted treatment (M-AT) options.[15]

Relevant Legislation

Since 2017, Indiana has taken multiple steps to stop the opioid epidemic, and although most of those were not explicitly intended to address family-level impacts, many have the potential for downstream effects on families by decreasing opioid availability and broadening treatment options. For instance, Indiana's state legislature integrated prescription-drugmonitoring programs with electronic pharmacy management and medical records systems,[17] and also placed new limits on first-time opioid prescriptions.[18] The governor's office reported that Indiana's 2018 opioid prescription rates fell by 23% from 2017.[19] Other legislation authorized municipalities to initiate needle- and syringe-exchange programs[20] and established new treatment facilities,[21] such that most Indiana residents now live within a 1-hour drive of opioid-specific treatment options. More explicitly related to families, legislation authorized inpatient treatment resources for women using opioids during pregnancy,[22] including family preservation and postbirth wraparound support, and also authorized a pilot program focused on maternal and neonatal addiction.[23]

Massachusetts

Opioid Misuse

In 2015, Massachusetts's opioid prescribing rate was lower than the national average, at approximately 60 prescriptions per every 100 residents – a number that declined further to 40 prescriptions per 100 residents by 2017.[24] However, also in 2017, Massachusetts reported 28 opioid-related overdose deaths per 100,000 residents, a

rate twice the national average (15 per 100,000),[24] ranking Massachusetts among the top 10 states for opioid-related fatalities. From 2012 to 2017, Massachusetts saw one of the sharpest increases in the United States in deaths related to synthetic opioids (e.g., fentanyl), from 67 deaths in 2012 to 1,649 in 2017, a 25-fold increase.[24] Furthermore, between 2004 and 2013, the number of opioid-exposed infants born in Massachusetts increased by a factor of six.[25]

Child and Family Welfare

In every year from 2014 through 2018, the percentage of families that the Massachusetts Department of Children and Families investigated for potential maltreatment has exceeded the national average by between 7% and 12%.26 In the aftermath of several tragic, high-profile incidents, Massachusetts's governor outlined a series of reforms involving the agency, including mandated standardized risk-assessment tools, enhanced supervision and case review, and strategies to promote recruitment and retention of social workers.[27] Shortly after, an audit of 2014–2015 operations confirmed that the agency had not been meeting standards related to proper reporting of critical incidents of maltreatment among statesupervised children.[28]

Relevant Legislation

In 2016, Massachusetts's state legislature unanimously passed the Act Relative to Substance Use, Treatment, Education, and Prevention, or the STEP Act, which was designed as a proactive approach to preventing opioid misuse through public education efforts and reducing the opioid supply.[29] The STEP Act was credited with a 29% decline in opioid prescriptions by the 2018 passage of a second major piece of legislation: Act for Prevention and Access to Appropriate Care and Treatment of Addiction.[30] This bill strengthened the STEP Act's education and prevention efforts, expanded the roles of recovery coaches, and widened access to treatment, and, according to the lieutenant governor, was informed by "valuable insight from

families, individuals with substance use disorders, providers, recovery coaches, and first responders into what it takes to effectively address the opioid crisis."[31] By 2018, the governor's office had doubled spending on opioid-related care from 2015 levels, adding thousands of beds to inpatient treatment centers and certifying nearly 200 sober-living facilities for after-care.[31]

North Carolina

Opioid Misuse

In 2015, physicians in North Carolina signed 87 opioid prescriptions per every 100 residents.[32] The state subsequently experienced surges in opioid-related overdose deaths, which increased by nearly 40% between 2015 and 2016,33 and increased again by an additional 29% between 2016 and 2017 – totaling a nearly-70% increase.[34] The rate of opioid-related deaths in North Carolina nearly doubled between 2010 and 2016,[32] and 60% of fatal overdoses in 2016 involved opioids (including synthetics).[35] Further, instances of prenatal opioid exposure increased over 20-fold between 2000 and 2013.[32]

Child and Family Welfare

In 2017, over 5% of children in North Carolina had contact with the state's Department of Social Services, slightly above the national average.[16] In 2016–2017, parental substance use contributed to 39% of child removals, up by 13% from 2007–2008.[36] In one county, all child removals were due (at least in part) to parental substance use.[36] During that same time, North Carolina's child welfare system was being overhauled in the aftermath of several high-profile incidents of child maltreatment and an independent audit that cited inadequate funding, poor staff training and retention, and high caseloads.[37]

Relevant Legislation

In 2017, the North Carolina state legislature passed the Opioid Action Plan (OAP), which focused on coordinating infrastructure, reducing the supply of both prescription and illicit opioids, increasing public awareness and prevention efforts, expanding access to emergency overdose-reversal drugs as well as long-term post-overdose aftercare treatment, and expanding treatment options, including folding M-AT into prenatal care when necessary. One year after OAP's implementation, prescription opioid prescribing fell 24%, opioid-related emergency room visits dropped for the first time in over a decade, and receipt of opioid-related treatment among uninsured individuals and those insured by Medicaid increased by 20%.[38] The 2019 OAP 2.0 more explicitly targeted impacts on families by addressing family-level risk factors for SUD (e.g., adverse childhood experiences); enhancing training for health care providers treating expectant mothers with SUD; and piloting an initiative to connect parents at risk for child removal to evidence-based SUD treatment, recovery support services, peer supports, and material resources for basic needs (e.g., transportation and housing).[38] The OAP 2.0 also expanded community-based treatment options (including M-AT) and developed "problem-solving courts" to divert low-level offenders out of penal institutions and into systems of care.[38]

Conclusion

Although each of the three states discussed here faces varying needs related to both opioid misuse and child protection, all are dealing with the changing landscapes resulting from the intersection of the two. All three states have passed sweeping legislation related to combating opioid misuse in recent years, although with slightly different foci and messaging surrounding these efforts. While all three states have reported gains made against overprescription of opioids and enhanced access to

addiction treatment, we know less about changes in child welfare–related outcomes that may result from these efforts.

Issues on the Horizon

Several issues at the intersection of child welfare and substance use are on the horizon for all U.S. states. First, child welfare systems nationwide are gearing up for several substantial changes with the impending implementation of the Family First Prevention Services Act (FFPSA) by 2021.[39] The FFPSA grants states more flexible access to federal Title IV-E dollars, which previously were allocated only for children in state custody (i.e., foster care). This will vastly expand states' options for responding to parental substance misuse without separating parents and children, but it will also require implementation of evidence-based programming—a new FFPSA requirement that is stressing state systems to identify and adopt approved programming. Although 39 states, including the three profiled here, have opted for 1- or 2-year delays in FFPSA implementation, all states must implement by 2021. This will drastically alter funding and service provision infrastructures of child welfare systems nationwide.

Second, some states are beginning to see a resurgence of methamphetamine use and overdose deaths, which will have implications for state child welfare entities. Colorado, for instance, has seen a 3-fold increase in methamphetaminerelated arrests since 2014, and in 2017, methamphetaminerelated overdose deaths exceeded those related to heroin for the first time in more than a decade.[40] There are currently no M-AT options approved by the Food and Drug Administration for treating methamphetamine addiction, as there are for alcohol and opioid use disorders; thus, many state child welfare systems may soon be faced with another epidemic.

Policy Implications

Several potential policy responses can ease the burden of the opioid epidemic on state child welfare authorities in both the short term and the long term.

1. States must invest in two-generation approaches to SUD prevention and treatment. We are passing the epidemic of substance misuse on to our children,[10] thus two-generation approaches to treating SUDs should focus not only on treating SUDs in parents, but also preventing SUDs and related issues for their children.[41] Funding should support SUD prevention and education efforts and early SUD detection for young people, with a focus on children of SUD-affected parents and caregivers. Timely, holistic, and accessible SUD treatments for whole families should be implemented.

2. Policy should optimize options for early detection and safe treatment of SUDs during pregnancy, with a focus on long-term well-being for parents and babies. Prenatal opioid exposure increased by about 380% between 1999 and 2013 in the United States, and 50–80% of exposed infants developed neonatal abstinence syndrome and associated neurodevelopmental, cognitive, and physical complications.[42] Further, an estimated 80% of hospital costs associated with this syndrome are paid for by state Medicaid coverage.[42] Thus, initiatives should fund widespread SUD screening protocols for pregnant individuals, training on detecting and treating SUD for health-care providers, including those serving in low-cost clinics and urgent care settings. These efforts should not be punitive toward individuals struggling with SUD during pregnancy.

   Further, investments should be made in programming that supports long-term success in sustained sobriety, safe parenting, and healthy child development. Programming should be mindful of exposure experienced by infants born to parents who stopped using illicit opioids during pregnancy but used M-ATs, which are also opioids. Parents also should receive education on the many potential needs of their children due to neonatal exposure to opioids and on parenting while newly sober. Finally, programming efforts to close the gap

between intensive inpatient treatments and community-based outpatient treatments to prevent relapse for parents with opioid use disorder should be emphasized.

3. Policy should support expansion of access to M-AT for individuals struggling with SUD, including parents in the child welfare system. Individuals who receive M-AT have been found to be less likely to use illicit opioids, contract infectious diseases commonly associated with substance use (e.g., HIV and hepatitis C), and suffer fatal overdoses.[43] M-AT has also shown much promise for treating opioid use disorder and increasing likelihood of reunification among parents in the child welfare system.[44] Thus, funding should expand access to M-AT for families receiving child protective interventions. And finally, training on M-AT (and related stigma) should be mandated for child welfare personnel.

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