



RESEARCH REPORT

Supporting Children and Families Affected by the Opioid Epidemic

Emerging Policy Considerations

Laudan Y. Aron

Sarah Benatar

Rebecca Peters

November 2020



ABOUT THE URBAN INSTITUTE

The nonprofit Urban Institute is a leading research organization dedicated to developing evidence-based insights that improve people's lives and strengthen communities. For 50 years, Urban has been the trusted source for rigorous analysis of complex social and economic issues; strategic advice to policymakers, philanthropists, and practitioners; and new, promising ideas that expand opportunities for all. Our work inspires effective decisions that advance fairness and enhance the well-being of people and places.

Contents

Acknowledgments	iv
Executive Summary	v
Supporting Children and Families Affected by the Opioid Epidemic: Emerging Policy Considerations	1
Background	1
Introduction	2
Methods	4
Findings	6
Systemic Misalignments, Barriers, and Resources	6
Community Needs and Promising Approaches	16
Discussion and Emerging Policy Implications	20
Opportunities to Support Children and Families	20
Making Policies “Family Proof” and Adaptive	21
Notes	24
References	26
About the Authors	30
Statement of Independence	32

Acknowledgments

Support for this research report was provided by the Robert Wood Johnson Foundation's Policies for Action program. The views expressed are those of the authors and should not be attributed to the Urban Institute, its trustees, or its funders. Funders do not determine research findings or the insights and recommendations of Urban experts. Further information on the Urban Institute's funding principles is available at urban.org/fundingprinciples.

This report would not have been possible without the knowledge and insights shared with us by national policy experts working at the Office of the Assistant Secretary for Planning and Evaluation (DHHS), the National Governors Association, the National Association of Counties, the Addiction Policy Forum, and the Alliance for Strong Families and Communities. Equally helpful and enlightening, were the cooperation and support of two local communities we visited in West Virginia and northern Kentucky. Local leaders, service providers, and family members were able to share the complex realities of managing this epidemic in their lives and communities, and added insights and perspectives we would never have otherwise had. We thank them for their time and trust.

The authors would like to thank Mayookha Mitra-Majumdar for help organizing and conducting interviews with national experts, and Haley Samuel-Jakubos for research assistance. This paper also benefited from the thoughtful review and input of Gina Adams, Lisa Clemans-Cope, Lisa Dubay, Kathleen Frydl, Genevieve M. Kenney, Bridgette Lery, Jessica Nickel, Kimá Joy Taylor, and Elaine Waxman. Any remaining errors or omissions are those of the authors alone.

Executive Summary

The opioid epidemic is one of the largest public health crises in a generation, and it takes place against a backdrop of deep and growing structural inequality in the nation's social, economic, and political landscapes. To date, most of the response to the opioid epidemic has focused on people directly affected by problem drug use and addiction. Yet, about 8.7 million children ages 17 and younger live in households with at least one parent with a substance use disorder, and an estimated 623,000 parents with opioid use disorder live with children.

A comprehensive approach to fighting the opioid epidemic must account for the unique needs of children and families, acknowledge the family caregiving roles and responsibilities of people who use drugs, and provide effective care and supports long before addiction emerges.

Drawing on interviews with national experts in the field and site visits to two Appalachian communities significantly affected by the epidemic, we sought to identify how the opioid epidemic is affecting children in families touched by problem drug use, how parents or caregivers could be better supported, and how service providers and systems could be better positioned to support families affected by the crisis. It is important to note, however, that the communities we visited do not represent the wide range of communities and local contexts relevant to this nationwide epidemic.

We also explore how systems and settings that support children and families are responding to the opioid crisis. These systems include early care and education, K-12 schools, primary and other health care settings for both children and parents, and, for parents, employment and training settings. We also investigate if and how safety net policies or practices have come into play.

Our conversations revealed wide-ranging unmet community needs and service system limitations, often tied to historical policy failures and/or regional economic challenges. People grappling with substance use disorders face limited access to treatment, as do their families, and child welfare systems are not equipped to meet the complex needs of children and families touched by the epidemic. And though schools and early childhood care programs can be a critical resource for families, these settings are universally overstretched and underfunded. And stigma, bias, and misinformation continue to impair efforts to address the epidemic.

But examples of promising programs and approaches also emerged. The following strategies can help protect communities and serve vulnerable children and families in the wake of this fast-moving and devastating epidemic:

- addressing long-standing system challenges and misalignments
- investing in community-based services and infrastructure
- pursuing trauma-informed care
- family proofing public policies while making them more adaptive and agile
- ensuring policies in mainstream settings reflect best practices and research-based evidence

This initial look at the opioid epidemic and its implications for child and family policy points to both extensive needs and opportunities within the nation's health and social care systems and the private sector. But to thoughtfully address the opioid epidemic's ongoing effects on children and families, more research is needed on ways to align systems that interact with one another when families are affected by crises.

Supporting Children and Families Affected by the Opioid Epidemic: Emerging Policy Considerations

Background

Fueled by overprescribing, the recent epidemic of opioid and related addictions and deaths has been unfolding in the United States for the past two decades.¹ It is difficult to overstate the epidemic's impact on the country, whether in terms of population health and survival (Haskins 2019; Scholl et al. 2019; VanHouten et al. 2019), human suffering and social disruption (Hagemeyer 2018),² or financial and economic costs (Council of Economic Advisers 2017; Florence et al. 2016). The epidemic takes place against a backdrop of deep and growing structural inequality in the nation's social, economic, and political landscapes, which some observers have argued are central to understanding the epidemic's root causes and devastating consequences (Case and Deaton 2017; Dasgupta, Beletsky, and Ciccarone 2018; Nosrati et al. 2019).³

To date, most of the response to the opioid epidemic has focused on people directly affected by problem drug use and addiction, along with two key systems at the front lines of the epidemic: clinical care/treatment and criminal justice. With a few notable exceptions,⁴ much less attention has been paid to the children, adolescents, and other family members affected by the epidemic, or to supporting people who use drugs *in their capacity as parents and caregivers*, an approach that may benefit both parents *and* their children (Zhang, Slesnick, and Feng 2017). As one expert noted, this focus on individuals rather than families has been out of necessity: "Because we're trying to put out the fire in terms of stopping overdose deaths, we haven't really been attending to other casualties, including kids, most importantly" (Collier 2018).

But we know that young children, adolescents, and others exposed to trauma, including problem drug use by parents, can experience a range of negative effects later in life, and the ripple effects of this exposure can be far reaching.⁵ A comprehensive approach to fighting the opioid epidemic or similar epidemics must account for children and families, acknowledge the family caregiving roles and responsibilities of people who use drugs, and provide effective care and supports long before addiction emerges.

Introduction

Opioid-related mortality is highest among young adults ages 25 to 34, followed by adults ages 35 to 44 (Gomes et al. 2018).⁶ These are childbearing and child-rearing ages, meaning any public health emergency affecting these age groups *ipso facto* affects the lives of children and adolescents. About 8.7 million children ages 17 and younger live in households with at least one parent with a substance use disorder (Lipari and Van Horn 2017), and more specifically, an estimated 623,000 parents with opioid use disorder live with children (Clemans-Cope et al. 2019). Failing to recognize the ripple effects of problem drug use and addiction within families (Brundage and Levine 2019), policymakers and service providers miss opportunities to support vulnerable children and families, and may even miss opportunities to treat and save the lives of parents who use drugs.

Communities across the country, including many at the forefront of the epidemic, are developing new approaches and models for combatting opioid addiction and overdoses (Brundage and Levine 2019).⁷ Simultaneously, the federal government has funneled additional funding to state and local agencies responding to the crisis, including grants from the Substance Abuse and Mental Health Services Administration, the Health Resources and Services Administration, and the Centers for Disease Control and Prevention.⁸ Also supporting people affected by the opioid epidemic is federal funding specifically targeted to children and families, including funds from the Families First Prevention Services Act, SUPPORT for Patients and Communities Act, Child Abuse Prevention and Treatment Act, the Center for Medicare and Medicaid Innovations' Maternal Opioids Misuse and Integrated Care for Kids demonstration projects, and Medicaid expansion (Brundage and Levine 2019).⁹ Other long-standing funding sources for children and their families include the Title V Maternal and Child Health Block Grant Program and the Individuals with Disabilities Education Act. However, for the activities supported by these funding streams to be effective, they must be evidence driven and promote families' health and well-being.¹⁰ And for policymakers and service providers to support these activities, they need to understand how children and families are affected by the epidemic and how best to respond.

The opioid epidemic's severity has meant many policy experts and practitioners have focused on more urgent "downstream" issues and systems, such as limiting the supply of opioids and related drugs and increasing access to addiction treatment (ASPE 2015).¹¹ Concerns about children and youth have been largely focused on neonatal abstinence syndrome and the child welfare system (Kocherlakota 2014).¹² The evidence of negative health and development outcomes for children exposed to parental problem drug use and related social factors is substantial (Lander, Howsare, and Byrne 2013; Romanowicz et al. 2019; Solis et al. 2012). However, much less research has focused on whether child

welfare systems have seen increased maltreatment or foster care involvement related to parental opioid addiction or how different policies and service systems can support children, parents, and family preservation, which may reduce rates of problem drug use (Seibert et al. 2019).

This study is an early-stage effort to start to fill this gap. Drawing on interviews with national experts in the field and site visits to two Appalachian communities seriously affected by the epidemic, we sought to identify how the opioid epidemic is affecting children in families touched by problem drug use, how parents or caregivers could be better supported, and how service providers and service systems could be better positioned to support families affected by the crisis. As such, we focus on system- and community-level effects of the crisis on families. We aimed to go wide rather than deep to surface questions and topics for future research, program, and especially policy development.

This report focuses on the nation's response to one of the largest public health crises in a generation—not on the policies and conditions that contributed to the epidemic, which are outside the scope of this project. Policymakers, researchers, and practitioners should, however, determine how this epidemic could have been prevented or mitigated and develop policies and practices that protect communities from similar catastrophes.

We also set out to explore how systems and settings that support children and families are responding to the opioid crisis. These systems include early care and education, K-12 schools, primary and other health care settings for both children and parents, and, for parents, employment and training settings. Additionally, because many parents, especially those whose lives have been significantly disrupted by substance use and addiction, may need to rely on income supports or other safety net programs to make ends meet, we also explore if and how safety net policies or practices have come into play.

Finally, in this early effort to bring a “family lens” to the opioid crisis, it is important to remember that people who use drugs (which may or may not be medically indicated) are not homogenous; they include people living with substance use and addiction disorders, but they also include people living with chronic pain or advanced illness and people living with (often unattended) underlying trauma, poor mental health, or serious mental illness (Serafini 2018; Gallagher 2018). Mental health and substance use conditions often co-occur within individuals, families, and communities and change over time. Add the following health system shortcomings to this baseline complexity, and it is unsurprising that existing service systems and policies yield, and in some cases contribute to, poor health outcomes:

- our continuously evolving understanding of problem drug use, addiction, evidence-based treatments, and harm-reduction strategies
- a mental health and substance use treatment system that has long been underdeveloped and continues to fall short in meeting current needs (Office of the Surgeon General 2016; Lipari, Park-Lee, and Van Horn 2015; Mechanic 2017)
- health conditions and treatment approaches steeped in overly simplistic, conflated, and erroneous narratives (even among service system leaders and professionals)
- racial and ethnic disparities in health care (due to interpersonal, institutional, and structural racism) across a range of illnesses and services (Smedley, Stith, and Nelson 2003)

In short, we widened the lens for examining how cross-sector policies can better support children, families, and communities most affected by the opioid epidemic for many reasons. We provide initial insights and thinking toward that end.

Methods

From mid-2018 through early 2019, we conducted telephone interviews with national experts and site visits to two Appalachian communities. In those communities, we learned from people addressing the opioid crisis daily, and we supplement insights from national leaders with these local perspectives. Those national leaders were staff within a major federal agency's planning and evaluation office (US Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation), two national associations supporting state governors and counties (the National Governors Association and the National Association of Counties), a national nonprofit devoted to eliminating addiction (Addiction Policy Forum), and a national membership organization of state and local child-, youth-, and family-serving agencies (Alliance for Strong Families and Communities). The latter also allowed us to speak with some of their local members during their monthly call; together, these experts and members cover federal, state, and local policy areas and multiple service systems relevant to these issues, including physical health care, substance use and addiction care, mental health care, child protection and other child and family services, education, public health, and criminal justice.

For more in-depth local perspectives, we visited two communities hard hit by the opioid epidemic, pioneering new supports for those most affected, and at the front lines of managing the epidemic's effects on children, families, and the community. We spent approximately two days in Huntington,

West Virginia, in late 2018, and two days speaking with stakeholders from communities in northern Kentucky and southern Ohio in early 2019.¹³ During these visits, we interviewed local leaders providing early care and education and treatment and recovery supports, child and family service workers, law enforcement, advocates, and caregivers of children in families with problem drug use. However, no two communities can represent the entire nation, and future studies should look at more and diverse communities and localities to develop a more complete picture of the opioid epidemic at the local level.

Given the broad, early-stage nature of this study, and on the advice of our Institutional Review Board for protecting study populations, *neither parents who use drugs nor their children provided direct input to this study*. These are essential groups to include in future studies, especially because their experiences and insights are critical to understanding the challenges families face, ways current systems and approaches support or undermine positive outcomes, and promising solutions.

In West Virginia, we met with staff and leaders of a local home visiting program;¹⁴ a major health system developing housing for mothers in recovery and their children; a new child care center that specializes in working with babies born to mothers who use drugs and their caregivers (and training other specialized child care providers); a community-based substance use treatment program; a focus group of school staff, including the superintendent, principals, attendance officers, and teachers; and a focus group of custodial grandparents caring for their grandchildren. In Kentucky, we met with and learned from school superintendents, a family court judge, recovery professionals, service providers for runaway and homeless youth, advocates, and a focus group of custodial grandparents caring for their grandchildren.

As noted, the two communities we visited do not represent the entire country or even the larger regions in which they are located. Recent research has documented extensive geographic diversity regarding the opioid epidemic (Kiang et al. 2019), which has profound implications for both policy and practice. Similarly, communities' underlying social and economic conditions and health care, justice, education, and especially child welfare systems vary greatly. Both communities we visited have experienced high rates of opioid use, overdose, and overdose deaths; at 49.6 deaths per 100,000 people,¹⁵ West Virginia has the highest age-adjusted rate of drug overdose deaths involving opioids, and the state has seen a significant increase in deaths due to synthetic opioids (e.g., fentanyl) since 2014. Kentucky has a similarly high rate of opioid-involved deaths, 27.9 deaths per 100,000 individuals, which is nearly twice the national average. Like in West Virginia, synthetic opioids have driven the overdose death rate since 2016. Kentucky and West Virginia also have among the highest

rates of opioid prescriptions in the country, behind Tennessee and Oklahoma, with 86.8 and 81.3 prescriptions per 100 people.

For years, both Kentucky and West Virginia have worked to combat the crisis and reveal the challenges and solutions with which communities at the front line are contending. This is a difficult task for obvious reasons, not least of which is the pervasive misinformation surrounding all aspects of the crisis. The perspectives in this brief demonstrate the realities individuals and communities are facing, but misinformation is also part of that reality.

Findings

In discussing the needs, challenges, and opportunities for supporting children and youth affected by the opioid epidemic, both national and state experts and leaders of community-based organizations responding to the crisis described a range of unmet community needs and service system limitations, as well examples of promising programs and approaches. The following broad themes emerged:

- Access to effective treatment remains limited, but family members also need supports and services.
- Stigma, bias, and misinformation continue to impair efforts to address the epidemic.
- Child welfare systems face a range of complex challenges in meeting child and family needs.
- Education and early childhood care settings can be a critical link to other needed services and supports for families.
- Investing in high-quality, community-based services and infrastructure is essential.
- Across all systems, trauma-sensitive and trauma-informed approaches to care are needed.

Systemic Misalignments, Barriers, and Resources

Interviews with national experts and site visits to Kentucky and West Virginia revealed wide-ranging barriers and misalignments across systems (e.g., health care, education, child welfare) that make addressing the opioid crisis difficult: people grappling with substance use disorders face limited access to treatment, as do their families, and child welfare systems are often not equipped to meet the complex needs of children and families touched by the epidemic. However, education and early childhood care settings can be a critical resource and link for families, despite being overstretched and

underfunded. In the following sections, we explore these topics in depth and how they can either complicate or address the effects of the opioid crisis on families and communities.

ACCESS TO EFFECTIVE TREATMENT REMAINS CRITICAL, BUT SYSTEMIC BARRIERS TO CARE AND EVOLVING PRIORITIES SUGGEST A NEED FOR NEW APPROACHES

National and local key informants raised concerns over limited access to effective treatment. In the communities we visited, we heard many different—and sometimes conflicting—accounts and narratives around the significant need for high-quality substance use treatment (for substances of all kinds), as well as the tremendous financial resources flowing into the community to address these needs. In West Virginia, significant substance use treatment funds were flowing into the community, primarily from federal sources. The resources have targeted health care settings, including hospitals and behavioral health care programs, and, in some cases, allowed health care providers to offer other needed medical services in addition to substance use services. Still, some observers noted the unmet need for and limitations on resources for various health-related social needs and preventive services.

Despite the recognized need for more and better treatment services, some community members were weary of the influx of new treatment services and service providers. This response may stem from a long history of outsiders exploiting communities in these regions, as well as a distrust of people who come to help but may also be from the same systems that helped facilitate the epidemic. Some community members mentioned how parts of the treatment system are newly flush with money and profits;¹⁶ as one frontline social service provider put it, “They used to mine us for coal, now they’re mining us for Medicaid dollars.” Another respondent said, “The government is the dealer now.” In some cases, these types of perspectives reflect and reinforce misunderstandings and stigma surrounding addiction, treatment, and government-funded programs (Stuber, Meyer, and Link 2008). They can also undermine efforts to connect people with needed care, and they demonstrate the need to continue educating and engaging with both the community and providers, especially in places that have not historically had a robust care system. Additionally, recent media profiles have revealed and characterized some portions of the care system as “the rehab racket,” which can undermine trust and perpetuate stigma throughout entire communities.¹⁷ It is vital that community-based treatment services be high quality and evidence based, as well as ethical and nonexploitative.

As some national experts consulted for this study explained, Medicaid is doing more to cover substance use treatment, like medications for addiction treatment (Orgera and Tolbert 2019),¹⁸ but access remains insufficient. Though West Virginia and Kentucky have expanded Medicaid coverage, not all states have done so. Even in states that have expanded Medicaid, many physicians do not accept Medicaid or cannot accommodate new patients. And though medications for addiction

treatment (namely methadone, buprenorphine, and naltrexone) are generally covered by Medicaid,¹⁹ some Medicaid and private health insurance plans implement cost-sharing requirements and utilization controls, like prior authorization, step therapy, and quantity limits, that prevent people from getting needed care (Peters and Wengle 2016). Additionally, office visits and care coordination are seldom covered.²⁰ Similarly, methadone, an effective treatment for opioid use disorder, is limited to licensed opioid treatment programs, meaning health care providers in office-based settings are less likely to refer patients to this treatment.

Multiple national and community-based experts we interviewed raised several long-standing issues within our health and social care systems that have made responding to the opioid epidemic more challenging. In addition to the misguided approach to substance use, addiction, mental illness, and trauma, respondents noted gaps and tensions between mental health and substance use treatment systems (i.e., the key components of behavioral health),²¹ and between behavioral health and the rest of the health care system, especially primary care. For example, the Health Insurance Portability and Accountability Act, 42 CFR, and other privacy protections and concerns can create barriers to sharing information among service providers who might benefit from coordinating and collaborating. Other barriers include lack of Medicaid coverage (especially in states that have not expanded Medicaid) and Medicaid enrollment and retention requirements. Federal policy also limits treatment availability; one interviewee reported that local officials prefer methadone because it is cheaper to administer, but federal and state policy constraints and stigma limit access to methadone (which can only be administered in the few approved clinics, whereas buprenorphine and naltrexone can be administered in less restrictive office environments).

Irrespective of how well addiction treatment dollars are managed at the local level (a topic well beyond the scope of this study), respondents' and informants' attitudes toward and perceptions of the treatment system, what it offers, how it works, and how well it functions varied widely. Many national experts commented about the need to better distribute and target resources to address all components of the epidemic—not just treatment. In addition to too little focus on prevention and early intervention, experts spoke about shortages of treatment providers, professional training, and access to existing treatment options. Another expert observed that no one is systematically tracking or managing the influx of federal funding for the opioid crisis, making it difficult for states to coordinate or optimize these funding streams.²² Others noted that federal resources do not always support the right things; one observer commented that a large share of funding is being spent on prescription drug monitoring programs, but little funding has been spent on identifying how the opioid crisis is affecting women, women of childbearing age or who are pregnant, communities of color, or children and youth.

Given severe resource constraints and budget shortfalls within local education and child welfare systems, allowing new opioid-related funding to support more efforts within these child- and family-serving systems could be helpful.

Experts identified several other system and policy misalignments affecting efforts to address the opioid epidemic. Policies and programs relating to substance use and addiction treatment have traditionally been developed for single men, and most policies and systems fail to recognize that many people they serve are parents, ignoring the responsibilities, concerns, and complexities this implies. We heard many examples of systematic disconnections between addiction treatment and child protection systems. In addition to a general lack of trauma-informed and family-preservation supports, time limits for family reunification (after which children are permanently placed in new homes) can be shorter than the period needed for a parent to stabilize in treatment. In some communities, parents must enter treatment within 30 days or risk having their child removed from their home, though wait times for treatment may be longer. Federal policies do not always reflect differing, complex state and local realities, and what the research shows are the most promising approaches often differ greatly from the policies and programs widely available in communities. Even if communities are aware of promising programs or best practices, many jurisdictions simply do not have the time, funding, capacity, or training needed to implement them (Attermann, Dormond, and Schreiber 2017; Dormond 2017).

In the two communities we visited, urgent, unmet needs relating to addiction, treatment, and (for some) their immediate ripple effects within families received the greatest focus and attention. However, both communities acknowledged the need to develop and act on longer-term and child-focused strategies. Both are proactively tackling the epidemic on multiple fronts and in some cases pioneering new approaches and solutions for their communities while managing population trauma, stress, and dysfunction. Though many innovations have been developed and lessons learned in other communities managing other public health crises, they have not necessarily been evaluated, incorporated, or spread through effective policies and practices. The current opioid crisis provides yet another opportunity for the country to identify and adopt more effective evidence-informed health and social policies.

CHILD WELFARE SYSTEMS FACE CHALLENGES MEETING CHILD AND FAMILY NEEDS

As noted, interviewees mentioned that many child- and family-serving agencies (not just child welfare) have not attended to substance use issues well and are simply unprepared to respond to the opioid crisis, given both the scale and nature of the problem. Both expert interviews and in-person site visits

revealed varied and contradictory policies and practices—especially evident in the child welfare system—seemingly driven by variation in local and state policies and practices, as well as capacity constraints.

Expert interviewees emphasized that state child welfare programs need help defining and operationalizing parental substance use and determining what circumstances should trigger a call to child protective services. Currently, states, communities, and judicial systems differ in their inclinations to remove children from their homes when a parent or caregiver has a substance use disorder (and under what circumstances). This is sometimes standardized in local policy (Child Welfare Information Gateway 2016) but often just depends on the preference of a local judge or official, who often has limited knowledge or evidence to guide best practices or policies. Some informants reported that children are entering the child welfare system because parents are *not* in treatment, whereas others explained that children are entering the system because parents *are* receiving addiction treatment. In one case, a local judge was automatically removing children from their homes when parents began receiving medications for addiction treatment, an evidence-based treatment for substance use disorders. On the other hand, we heard parents with opioid use disorder were being sent home with naloxone, which prevents overdose, when they were forced to choose between seeking treatment in another state—and being separated from their children—or going without treatment because none was available locally. These inconsistencies, often within the same community, create confusion and fuel distrust and misinformation. For example, one common misconception is that the Child Abuse Prevention and Treatment Act requires that all substance-exposed newborns be reported as being abused or neglected (National Advocates for Pregnant Women 2018). In short, communities need clear guidance on existing child welfare laws, especially as they relate to substance use and addiction.

In response to these policy challenges, some communities and states have adopted new approaches to child welfare practice: One example is Safety Organized Practice, a grassroots, strength-based practice evolving in California.²³ Another example is Baltimore’s Family Recovery Program,²⁴ which shortens children’s time in foster care, promotes family reunification, and saves money. More work is needed to document the variation in child welfare responses across communities, the policies driving these responses, outcomes for family members and communities, and emerging and best practices. Despite these extensive knowledge gaps, key informants agreed on the critical need to help parents get healthy, support nonparent custodians, and avoid parent-child separation when possible.

One way of meeting these needs is to have an explicit two-generation focus. Generally, interviewees agreed that more attention should be paid to two-generation treatment approaches to

keep families together, but capacity for this treatment is uncertain. The Fostering Connections to Success and Increasing Adoptions Act of 2008 supports models in which children can remain with their parents while in treatment,²⁵ an approach being implemented in some states and counties. The Comprehensive Addiction and Recovery Act of 2016 requires that treatment address both children's and caregivers' needs,²⁶ so many states are considering ways to get caregivers into treatment while keeping children in their care. Several experts noted, without sharing specifics, that much can be learned and adapted from communities' experiences with family drug courts,²⁷ especially given widespread evidence that drug use and addiction are best addressed as health and social welfare issues, *not* criminal justice issues (Csete et al. 2016).

Interviewees also raised concerns about policies around visitation managed by social services or law enforcement (as opposed to in more informal kinship care). Several key informants noted that these policies and practices can be inflexible, arbitrary, and nonsensical and shared that some decisionmakers do not allow visitation by parents with *any* indications of drug use, even if they are in recovery and functioning well. This practice undermines efforts to maintain parent-child bonds, which are often critical to everyone's stability and well-being.

In addition, some respondents mentioned that the child welfare system is not well equipped to attend to the needs of older children or adolescents, because younger children have historically been its focus. In turn, these children are left vulnerable. Among older children, child welfare is more likely to get involved when and if they develop a substance use problem, rather than protecting them from traumatic or high-risk situations in which a parent or caregiver is using drugs.

Despite the child welfare system's limitations, experts noted that the epidemic has drastically increased the child welfare population in some communities (Ghertner et al. 2018; Radel et al. 2018), though more empirical work is needed on this topic. Not only are more children entering in the system, they are also coming in at younger ages, their needs are greater, and they are staying longer—all of which complicate case management and drive up costs. Without family preservation programming and family supports, these trends can result in major shortages of foster parents for two reasons: (1) because there are too few to meet the growing need, and (2) because many existing foster parents are unprepared to care for children who have experienced trauma or the effects of neonatal substance exposure, and child welfare agencies cannot provide the support these foster parents need. This is exacerbated by shortages of licensed professionals in many communities, putting additional strain on a flooded system. Consequently, some states are considering or implementing policies to increase staff prepared to work with substance use-involved families, such as mobilizing

undergraduate students with relevant coursework. However, many new graduates face stigma and student debt, making recruitment challenging.

Given the growing child welfare population, national and local experts highlighted critical needs relating to both kinship care (care by relatives or, in some jurisdictions, close family friends) and foster care, but kinship care especially does not get sufficient resources or policy attention. Providers and family members alike described complexity, confusion, and even trauma when interfacing with the child welfare system, especially with individual child welfare workers giving different and often conflicting information in response to similar questions by different family members or families. The conflicting information and confusion seemed to add to the trauma and stress experienced by many families, which was compounded when families (and child welfare systems) spanned states with different rules and regulations.

Interest in what makes for quality kinship programs has grown, especially for grandparents assuming care of their grandchildren. Many grandparents have had to leave the workforce to care for their grandchildren and may be drawn into custody battles with their own adult children. To further complicate things, we heard about ever-changing and opaque policies related to kinship care payments during our Kentucky site visit; the funding is highly variable over time, making it difficult for kinship care providers to get the financial support they are eligible for and need. As one caregiver explained, “We’ve been able to work things out, but it feels like nobody cares.” Kinship caregivers—often grandparents—also face challenges enrolling children in school and accessing medical records; though legal recourse (and free legal services) may be available, it can be difficult for grandparents to know where to start. One caregiver noted, “I wish someone had told us to adopt her and when and how.”

In other cases, we were told that some grandparents “have been through this already” and are unwilling to step in a second time. Many foster parents, adoptive parents, and kinship care providers are not given the tools or supports to meet the needs of children who have sequelae from neonatal drug exposure or early childhood trauma. Multigenerational drug use, which is widespread in some communities, is another complicating issue; one factor behind the shortage of foster care placements is that the people who would normally step in to care for children (extended family members and friends) may also be using drugs.

Interestingly, national and local experts rarely mentioned various *in-home* family preservation models that can effectively support substance use-involved families while (often) preventing child removals. One recovery-oriented, trauma-informed, in-home substance use disorder treatment model,

known as Family-Based Recovery, originally developed for the Connecticut Department of Children and Families, uses therapy and substance use disorder treatment to help parents overcome substance use disorders while improving the parent-child relationship (Casey Family Programs 2019).²⁸ Home visiting is another potential support for young children and families affected by drug use. Home visitors are nurses, social workers, or other trained paraprofessionals who work with families and children in their homes to improve child and maternal health outcomes and prevent child abuse and neglect. We met with a group of home visitors in West Virginia who described screening for conditions, making referrals for treatment (when available), and coordinating with other agencies that support families. However, home visitors noted that community resources were not always available or sufficient to meet the needs of families affected by drug use, and that not all home visitors had received training on how to address opioid or other drug use at home, resulting in situations that sometimes felt unsafe. These are just two options among a range of other family preservation service models, program approaches, and legislative strategies that can help communities grappling with opioid and related drug crises (AECF 2001; Freundlich 2020; Ringel et al. 2017; Roberts 1999).²⁹

EDUCATION AND EARLY CHILDHOOD CARE SETTINGS ARE A CRITICAL LINK AND RESOURCE

Beyond the child welfare system, early childhood care settings and schools are managing care and support for children and families affected by the opioid epidemic. Schools play a major role in supporting children exposed to drug use at home, and teachers, administrators, and staff may be well positioned to respond to some of their needs. As one key informant explained, “So often the focus is on the adults involved, and children are forgotten. One place they are not forgotten is in schools.”

In both communities we visited, school leaders and staff gave examples of the kinds of challenges their students experience daily. They described significant trauma and behavioral problems among students of all ages, large and growing shares of students directly or indirectly affected by opioid use at home, and the difficulty of prioritizing education when students are facing so much trauma in their homes and neighborhoods. School officials spoke of parents dropping off children at school while under the influence of drugs; school custodians finding syringes in the mulch at elementary schools and children being trained not to touch them; schools going into lock-down because of “drug busts” at nearby homes; students worrying about the recent arrest and incarceration of a parent, or the return home of a parent after imprisonment; and students being given new school supplies, backpacks, or clothes by the school only for them to disappear, presumably because their parents sold the items. Schools are also dealing with high mobility rates among their student bodies; respondents reported children commonly change schools as their parents move, and frequent moving is disruptive for

families, of course, and makes it difficult for students to learn and for schools to build strong relationships with children and their families.

In response to these substantial needs, schools are providing an array of supports to children and families: school meals, including breakfast, lunch, and after-school (dinner) meals; “backpack food” programs, which provide children with nonperishable food to ensure they have enough to eat over weekends and holidays; school-based food pantries; and Walmart-sponsored Stuff the Bus events that provide students with free school supplies, hygiene products, and other necessities. In addition to helping meet these basic needs, schools and staff are also increasingly interfacing with behavioral health programs, the child welfare system, law enforcement, and the court system. Interviewees highlighted the importance of strong relationships with people within these systems, noting that often they text one another throughout the night and over weekends about ways to support individual students or address incidents. But school-based human resource and technical assistance needs remain great; respondents stressed the need for more counselors, nurses, therapists, social workers, special education providers, and resource and truancy officers in schools. Interviewees also mentioned the need for trauma-informed training and support for all staff, most of whom have not received training on how to meet some children’s significant needs. As one respondent in Kentucky explained, there is “so much pressure on schools to do *everything*,” yet funding for many of these services and positions is often limited or unreliable.

Needing to manage more needs and complexities with few additional supports or resources, schools are not always well positioned to implement and benefit from various evidence-based practices, such as positive behavioral interventions and supports.³⁰ During our site visits, schools were also facing funding and staffing constraints. In Huntington, West Virginia, the local school district had recently launched initiatives to support children possibly affected by a parent’s drug use: (1) two new alternative schools devoted to children with disabilities (that may be unrelated to parental substance use but may require additional skills and supports from parents) and (2) a pilot program, Handle with Care,³¹ where police notify schools when a student has witnessed a traumatic drug-related event at home, like an overdose or arrest. However, at the time of our visit, Handle with Care had been suspended indefinitely because of a cut to the civilian staff position responsible for the program within the local police department.

Likewise, in northern Kentucky, key informants noted the tremendous value of (and great reliance on) family resource centers within schools, but their staff members are stretched thin. Family resource center staff members establish relationships with families, help students meet emergency needs, and help facilitate connections to various resources, such as families-in-transition coordinators who work

with homeless families. Respondents also discussed the need to fully fund schools, because full-day kindergarten is supported by general funds or parent fees in some cases, and the ways certain accountability policies are punishing schools and students, because of perverse incentives to not retain transient kids, who may be troubled and struggling academically. Schools in the area are using Botvin Lifeskills Training,³² but it is unclear how widely the program is being implemented throughout the state or with what effects. Prevention program funding is also intermittent; schools have implemented such programs only for the funding to later run out. How schools are using Medicaid funding for certain school-based health services is also unclear. Some schools in northern Kentucky offer (and fund) Drug Free Clubs of America,³³ in which students who join submit to random drug testing, which some local employers view favorably. Not all programs are based in evidence (or have not been studied yet), and most respondents did not discuss the evidence or effectiveness of specific programs or initiatives. Well-formulated policies and other guidance for states and localities can help communities steer toward appropriate evidence-informed approaches or document the effects of programs still in development.

In both communities we visited, concern about the health, well-being, and functioning of children exposed to drugs in utero and as young children was widespread. Teachers and school leaders reported seeing an increase in behavioral issues among very young kids, which they partly attributed (possibly incorrectly) to neonatal exposure to drugs and alcohol, as well as other early childhood traumas and adverse experiences. Communities are responding in kind: in West Virginia, we visited a former child care center being redesigned, and about to reopen, for babies and young children affected by opioids and other drugs. The highly experienced staff members were also working closely with experts from the local university to develop a new curriculum for training other child care staff on working with children and families with similar challenges. In many ways, they are building a new program and pioneering new approaches and interventions in response to the significant needs in their community.

In Kentucky, community leaders spoke about the critical need to prioritize early childhood education and care. In high-quality early childhood programs like Early Head Start, children and families can receive critical early intervention supports, identify and attend to developmental delays, perhaps prevent primary or secondary disabilities, and benefit from age-appropriate social interactions and relationship building well before kindergarten. Pediatricians and other health care providers also have an important role to play in screening for, diagnosing, and treating conditions that require medical care and in referring families to appropriate community-based services and supports. Key informants observed, however, that many families touched by the opioid epidemic are not benefiting

from these services or supports. Families may also be reluctant to seek help to avoid inappropriate child welfare system involvement or having their children stigmatized.

Community Needs and Promising Approaches

The broad systemic issues outlined above negatively affect real people: the communities, families, and individuals such systems intend to serve. In addition to facing systemic barriers, communities are contending with rampant misinformation surrounding many aspects of the epidemic, making it harder to effectively address and discuss addiction, treatment, and recovery. Communities also grappling with economic decline or poor infrastructure (e.g., limited job opportunities, deteriorating social safety nets) may be limited in their abilities to respond to new and growing needs. Together, these issues compound the trauma communities are experiencing. To move forward, communities require appropriate resources, trauma-informed approaches across all health and social systems, and collaboration and colearning with similar communities.

STIGMA, BIAS, AND MISINFORMATION CONTINUE TO IMPAIR EFFORTS TO ADDRESS THE EPIDEMIC

Key informants noted the need for a major “culture shift” regarding substance use and addiction treatment. Though they acknowledged the significant investments in treatment programs, they suggested more investments are now needed for effective recovery supports, especially those that acknowledge the chronic and episodic nature of addiction and relapse. One person characterized this as “responsible recovery,” a potentially stigmatizing term that moralizes drug use and treatment. Others noted that government and community leaders do not talk enough about the root causes or social determinants of addiction, the brain science of addiction and related trauma, or addiction’s widespread impacts on children and families. This lack of awareness of root causes is also reflected in how funds are being spent; considerable funding has gone toward the most immediate and visible consequences (e.g., overdoses and child removals), and less time, education, and resources have been devoted to prevention, early intervention, or the ripple effects of substance use, addiction, and related trauma within families and communities. During our site visits, we heard about the need for more education around drug use, addiction, harm reduction, treatment, and recovery, as well as corresponding language that is accurate, accessible, consistent, and compassionate. Such strategies are likely essential to reducing the ignorance, stigma, and bias that continue surrounding these issues in communities across the country.

Though interviewees agreed that more prevention, treatment, and recovery supports are needed, community members continually resist placing those services locally. Many people still view drug use and addiction as a choice and relapse as a failure. Respondents noted the myths, misconceptions, and stigma that surround substance use and addiction, as well as involvement in the child welfare and criminal justice systems. They noted that stigma is not limited to substance use itself but extends to treatment and recovery as well. As some national experts explained, in some communities, receiving medications for addiction treatment automatically voids parental custody rights; this is at odds with clinical evidence and owes not to any specific policy but to bias and ignorance on the parts of some judges and social workers. Conversely, some child welfare programs in other communities and states may only get involved when specific types of child maltreatment are documented, *irrespective of* parental drug use or addiction treatment.

Combatting stigma is not limited to members of the public or the community but extends equally—and perhaps more importantly—to service providers, professionals, and paraprofessionals spanning health care, education, social services, criminal justice, and other systems, as well as members of the media and business community. Given ever-evolving evidence and knowledge bases and corresponding changes to effective language and communication regarding drug use, addiction, treatment, and recovery, combatting stigma will be an ongoing need (Barry, Sherman, and McGinty 2018; Collins et al. 2018; Wakeman 2017).

INVESTING IN COMMUNITY INFRASTRUCTURE IS PART OF THE SOLUTION

Experts commented on the effects of geography, community conditions, and jurisdictional boundaries on efforts to address the opioid crisis. Though general, many of their comments suggested important areas for future research and nuanced program and policy development. Several comments focused on urban-rural differences: though the epidemic has affected all communities, red and blue states, urban and rural communities, and people of all socioeconomic statuses, policy experts noted differences in treatment availability, options, and approaches in rural areas. Others acknowledged that complex challenges like the opioid epidemic are harder to combat in rural areas, and policymakers should consider geography and what is most helpful and needed in rural versus urban areas.

These comments are supported by the research literature on substance and opioid use treatment in rural areas (Pullen and Oser 2014).³⁴ The challenge of service provision, especially behavioral health services, in rural and frontier communities is not new. Sawyer, Gale, and Lambert (2006) observed the following:

Rural areas (areas characterized by low population density, limited and fragile economic base, cultural diversity, high level of poverty, limited access to cities) have incidents of serious mental and behavioral health problems (depression, suicide, alcohol and substance abuse) equal to or greater than urban areas. Equally troubling is the insufficient volume and range of services available to treat mental and behavioral health problems in rural areas. Not only do rural areas have shortages of behavioral health professionals and specialized behavioral health services, but the turnover rate for service providers is high, and providers that remain often express feelings of isolation from other health professionals. These conditions are exacerbated in isolated rural and frontier areas and areas with concentrations of poverty and migrant and seasonal farm workers.

Many rural communities also face deteriorating infrastructure, limited employment opportunities, a severely limited workforce, a fraying social safety net, and a declining population base, all of which make it difficult to build an effective behavioral health service system or address the social determinants of drug use and addiction. A lack of funding for evidence-based practices developed specifically for rural areas, the higher cost of service delivery in rural areas due to fewer patients, and the long distances patients and service providers must travel are also significant barriers. The opioid epidemic has simply brought many of these long-standing realities and challenges into sharper relief.

Interestingly, when asked *what was most needed* to help their local communities, almost all local respondents turned the conversation toward the local economy, unemployment, and the need for more and better opportunities for younger community members. As one respondent from West Virginia shared, “Our young people have dreams, but they don’t have much hope.” And another one from Kentucky explained, “If people are stable in their job and they see opportunity, they are more likely to stay safe.” In addition to noting which major employers remained in the area or had recently left, interviewees discussed employers’ difficulties hiring people without criminal records, and how few employers will train or employ people in recovery. In Kentucky, state legislation that allows felonies to be expunged after five years without drug use appears to be helping. Also in Kentucky, a residential drug treatment program has developed a catering business for residents as part of their recovery and uses the revenues for the cost of treatment services.

Experts also pointed to growing interest in how the opioid crisis is affecting the workforce and labor market in communities that may already be experiencing economic downturn. Substance use, addiction, treatment, and stigma can be major barriers to stable employment, so studies are needed on the labor market impacts of the epidemic, as well as on growing efforts to expand “recovery-friendly” workplaces and employment,³⁵ which view recovery from addiction as a strength and are willing to work intentionally with people in recovery.³⁶ These issues may be especially important to parents in recovery who need to continue supporting their children and families economically, in addition to their other responsibilities as parents and caregivers.

National and local respondents made several other observations relating to community conditions and geography. One noted that when a child's grandparents or other relatives live in a different state, more time is needed to transfer a child from foster care to kinship care, which can increase the likelihood of trauma and poor outcomes for families. Another noted that more treatment providers operate in predominantly white communities than in communities of color. Yet another suggested that when substance use is multigenerational, someone in recovery might benefit most from simply leaving that community rather than seeking treatment there. These observations are worthy of additional study and investigation.

TRAUMA-INFORMED APPROACHES ARE NEEDED IN ALL CARE SYSTEMS

In addition to drug use and addiction, the communities we visited in Kentucky and West Virginia face structural issues that predate the opioid epidemic, including high levels of poverty, homelessness, transience, incarceration, and violence. Many children and youth also witness or experience disrupted adoptions, drug busts and arrests, sexual violence and assault, sex trafficking, and psychological distress, including suicide. Thus, several respondents said more services and programs should be trauma informed, especially when children and their safety are involved (Heffernan and Viggiani 2015). The widespread, damaging effects of trauma were very apparent in both communities. Despite our primary focus on the opioid epidemic and its ripple effects on children and families, interviewees agreed that mental health and trauma-related needs were as critical as those concerning substance use and addiction. And these needs are not limited to people who use drugs and their immediate families, but extend to frontline workers and other community members supporting them. One community leader described their handling of the opioid epidemic as “crisis management by the seat of our pants.”

The concept of traumatic stress originated within the mental health field more than four decades ago among women trauma survivors and has now spread across a range of not only behavioral health services but also child welfare, criminal and juvenile law systems, and even mainstream systems like education, primary care, and employment (SAMHSA 2014).³⁷ In general, trauma-informed approaches, programs, or systems of care recognize and incorporate principles of safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment, voice, and choice; and cultural, historical, and gender contexts (SAMHSA 2014). Though these issues are not unique to this point in time or the opioid epidemic specifically, they are important reminders about the inadequacy and fragility of support systems for people needing care. They also highlight the lack of support for many individuals at the front lines of the epidemic in communities across the country (e.g., first responders, care providers, teachers).

Though there has been a crisis response to the epidemic in hard hit communities, such communities have not been able to consider how to integrate trauma-informed approaches to the various systems that interact with families involved in the epidemic. These systems range from child welfare to criminal justice, from addiction treatment to mental health care, and from medical care for exposed neonates to physical health care for youth and parents. One system, public education, could be leveraged to support children and families given its central role in their lives. And the public at large, but especially those in positions of power and influence, can benefit from trauma-informed language training and policy approaches to mitigating the effects of trauma and toxic stress on families and individuals.³⁸

Communities can more thoughtfully address the opioid epidemic through collaboration with similar communities. In the Kentucky and West Virginia communities we visited, local leaders, service providers (spanning health care, education, and social services), and other community organizations were coming together and tackling growing child and family needs in the wake of the opioid epidemic and within an already underresourced service system and underperforming local economy. We also encountered highly dedicated community leaders and members, many of whom were doing more with less, developing new programs, and pioneering new models and approaches in response to significant local challenges. Several of them expressed interest in sharing and learning from their counterparts in other similar communities but did not always know how or where this colearning could happen.

In summary, the national experts and local leaders interviewed for this study indicated state and local policymakers are interested in actively supporting children and families affected by the opioid epidemic. Most needed to support this effort are studies identifying emerging, promising, and best practices for different types of communities, model policies that can advance them, and resources to implement them and sustain them over time.

Discussion and Emerging Policy Implications

Opportunities to Support Children and Families

Insights from both national experts and our site visits reveal widespread needs and opportunities for supporting children, youth, and families affected by the opioid epidemic. These opportunities extend to policies and practices in health care, behavioral health care, and public health; child protection and other child and family services; child care and education; and (for now at least) criminal justice (Volkow et al. 2017). The epidemic has made evident long-standing limitations and misalignments within our

health and social care systems related to geography, community conditions, or jurisdictional boundaries of different systems; resource limitations due to siloed service systems and funding streams; and ignorance, bias, and stigma surrounding substance use, addiction, and trauma, as well as treatment, relapse, and recovery (including the failure to address these as health issues, rather than criminal justice issues). Opportunities for supporting children and families include the following:

- ensuring all community members have access to effective prevention, screening, treatment, recovery, and harm-reduction services, and that these services anticipate and accommodate family-related responsibilities and parents' needs
- identifying children at risk as early as possible and providing them and their families with supports, such as home visiting, family preservation and reunification, and recovery assistance, in home- and community-based settings (e.g., child care and early education centers and schools)
- enhancing coordination between various agencies, including health care and public health agencies and child- and family-serving organizations
- providing effective supports to grandparents and other caregivers newly parenting children in the community (e.g., legal guidance, financial assistance, connections to schools and support groups)
- countering misinformation, stigma, and bias related to substance use, treatment, and recovery and educating community members and leaders about trauma, addiction, harm reduction, and where people can get evidence-based treatment and other supports
- improving economic conditions and job opportunities for people who use drugs, those at risk of using drugs, and young community members

Making Policies “Family Proof” and Adaptive

Any public health emergency, but especially one affecting people of childbearing and child-rearing age, is best viewed through a lens of child and family policy, suggesting the need to “family proof” public policies, a concept analogous to “rural-proofing.” The latter concept, which first emerged in Northern Ireland in the early 2000s, carefully, objectively examines policies (often developed in and for urban areas) to determine differential impacts for rural areas. When necessary, policies may be adjusted for rural needs and contexts.

Given how many parents and families with children have been affected by the opioid crisis, many opioid and related policies need to be updated and family proofed. Perhaps most importantly, this means all research and policies should reflect (centrally) the insights, experiences, and preferences of parents who face or are at risk of facing substance use and addiction. It also means instilling within child and family service systems a range of policy supports relating to addiction, harm reduction, trauma, and recovery. Trauma-related insights and principles are slowly extending beyond trauma-informed practice or care and into trauma-informed *social policy* (Bowen and Murshid 2016), a development that should be monitored and studied. Perhaps the significant resources flowing toward addressing the opioid epidemic can trigger long-overdue, evidence-informed investments in a broader substance use prevention and treatment system—and mental health and trauma treatment system—that has never been adequately developed or supported in the United States.

Family proofing opioid and related policies also means core substance use and treatment systems acknowledge, respect, and even harness the family and caregiving roles of people with addiction disorders. Many substance use treatment programs and settings have been developed by and for single men, but all people have been and can be affected by the opioid crisis and can have active parenting and caregiving responsibilities.

Early intervention and prevention are key strategies for addressing drug use, addiction, mental health, and health generally for not only *individuals* but also *systems*—in this case health, education, and social services. The funding and policies needed to support parents and children touched by the opioid epidemic should not be limited to specialized “deep-end” systems, such as addiction treatment, child welfare, runaway and homeless services, safety net programs, or the juvenile or criminal justice systems—as important as these are. Strong evidence-informed policies and practices are also needed in *mainstream* settings and systems that serve families: schools, workplaces, primary care offices, faith-based groups, and the community at large. Based on this high-level review, responses to the opioid epidemic seem to concentrate on systems most immediately and urgently affected by the opioid epidemic, especially addiction treatment and child welfare.

A fast-moving and devastating drug epidemic like the opioid crisis also calls for much more agile and adaptive policy and practice, especially at the intersection of service sectors and across jurisdictional boundaries. Policy experts and service providers alike noted how much they value and seek additional peer learning opportunities, pointing to the importance of creating and sustaining collaborative innovation and learning networks in this space.³⁹ Another potentially valuable contribution to the field would be a policy and implementation observatory (Chevarria et al. 2015), which could complement practical collections of best and promising practices, like the Addiction Policy

Forum’s Innovation Now and Spotlight Series⁴⁰ and various What Works Clearinghouses, such as the Washington State Institute for Public Policy, the Child Welfare Information Gateway, and the National Registry of Evidence-Based Programs and Practices,⁴¹ which was recently suspended by the Substance Abuse and Mental Health Services Administration (Green-Hennessy 2018).

The need for rapid policy responses in the wake of fast-moving or fast-changing public health emergencies like the opioid epidemic suggests a more prominent role for adaptive policies. Emerging insights from complexity science and complex adaptive systems have implications for policy design. Carey and colleagues (2015), for example, calls for more adaptive policies that

- perform well under a range of anticipated conditions with little or no alteration;
- include monitoring processes that identify changes in context significant enough to affect performance;
- have built-in triggers for adjustment (including deliberations for determining policy adjustments and a review process), meaning they can maintain performance or terminate when no longer needed;
- and, ideally, can accommodate unforeseen changes in context for which the policy was not originally designed, ensuring policy goals can be achieved despite unanticipated issues.

Adaptive policies may be critical to staunching the opioid epidemic and addressing other similar cross-cutting drivers of health, because they not only accommodate but *anticipate* differences in individual, family, and community conditions. Given that the opioid epidemic has already spread geographically, played out differently across the country (Kiang et al. 2019), and will likely continue evolving, communities need culturally appropriate, evidence-informed policies that work under various circumstances. Adaptive policies can protect certain communities from new burdens (e.g., budget cuts or new administrative requirements) and support them more proactively (e.g., through technical assistance or additional funding). For example, health professional shortage areas, as designated by the Health Resources and Services Administration, could be targeted for additional protection or support from the US Departments of Education and Health and Human Services.⁴²

This high-level look at the implications of the opioid epidemic for child and family policy points to extensive needs and opportunities within the nation’s health and social care systems, including the private sector. These opportunities include addressing long-standing system challenges and misalignments between policies and practices in the health care, social services, and education systems; family proofing public policies while also making them more adaptive and agile; and ensuring policies in mainstream settings reflect the best available research- and practice-based evidence.

Notes

- ¹ “Understanding the Epidemic,” Centers for Disease Control and Prevention, December 19, 2018, <https://www.cdc.gov/drugoverdose/epidemic/index.html>; Maya Salam, “The Opioid Epidemic: A Crisis Years in the Making,” *New York Times*, October 26, 2017, <https://nyti.ms/2iATbrJ>; “Ending America’s Opioid Crisis,” WhiteHouse.gov, accessed February 26, 2020, <https://www.whitehouse.gov/opioids/>; “What Is the US Opioid Epidemic?” US Department of Health and Human Services, September 4, 2019, <https://www.hhs.gov/opioids/about-the-epidemic/index.html>.
- ² “Working Together to Address the Multigenerational Effects of the Opioid Epidemic,” Milbank Memorial Fund, October 31, 2018, <https://www.milbank.org/news/working-together-to-address-the-multigenerational-effects-of-the-opioid-epidemic/>.
- ³ Though this paper refers to “the opioid epidemic,” opioid overdose deaths since 2002 have been linked to three distinct epidemics (relating to prescription opioids, heroin, and prescription-synthetic opioid mixtures) and one “syndemic” involving all three. These epidemics have played out differently over time and place, with varying effects on certain communities and groups of people, especially those that have been subject to economic disinvestment or social exclusion (Peters et al. 2019). Though we acknowledge the importance and complexity of multiple epidemics and types of drugs, they are not the focus of this paper.
- ⁴ These include the following: “Opioid Factsheets,” American Academy of Pediatrics, accessed February 26, 2020, <https://www.aap.org/en-us/advocacy-and-policy/federal-advocacy/Pages/Opioid-Factsheets.aspx>; Jaia Peterson Lent, “Grandparents Are Raising the Children of the Opioid Crisis,” *Aging Today*, American Society on Aging, accessed February 26, 2020, <https://www.asaging.org/blog/grandparents-are-raising-children-opioid-crisis>; Amanda Litvinov, “Teaching the Children of the Opioid Crisis,” *neaToday*, accessed February 26, 2020, <http://neatoday.org/2019/01/14/teaching-the-children-of-the-opioid-crisis/>; recent reports by United Hospital Fund and the Milbank Memorial Fund (Brundage and Levine 2019), the National Academy for State Health Policy (Normile, Hanlon, and Eichner 2018), and various societies and professional associations, including the American Academy of Pediatrics (AAP 2019) and the American Psychological Association (Collier 2018); and media features (e.g., Jennifer Egan, “Children of the Opioid Epidemic,” *New York Times*, May 9, 2018, <https://www.nytimes.com/2018/05/09/magazine/children-of-the-opioid-epidemic.html>).
- ⁵ See, for example, Tilson (2018).
- ⁶ Children are also dying. Between 1999 and 2016, 8,986 children and adolescents died from prescription and illicit opioid poisonings, a mortality rate increase of 268 percent (Gaither, Shabanova, and Leventhal 2018).
- ⁷ See the Addiction Policy Forum’s (2019) Innovation Now and Spotlight Series, <https://www.addictionpolicy.org/solutions>.
- ⁸ “HHS Awards over \$1 Billion to Combat the Opioid Crisis,” US Department of Health and Human Services, September 19, 2018, <https://www.hhs.gov/about/news/2018/09/19/hhs-awards-over-1-billion-combat-opioid-crisis.html>.
- ⁹ See appendix B of Brundage and Levine (2019) for a brief description of some of the most recent funding sources.
- ¹⁰ See, for example, National Advocates for Pregnant Women (2018), which addresses common misconceptions about what states must do with newborns with prenatal drug exposure under the Child Abuse Prevention and Treatment Act.
- ¹¹ These may or may not be done effectively. Limiting access to drugs in the middle of a public health crisis without corresponding, evidence-based harm-reduction approaches can exacerbate the crisis. Similarly, offering

addiction treatment that is not evidence based, trauma informed, or culturally appropriate will likely have limited positive effects.

- ¹² “Child Welfare and Substance Use,” US Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, accessed February 26, 2020, <https://aspe.hhs.gov/child-welfare-and-substance-use>.
- ¹³ Several candidate sites were identified based on recommendations of national experts and researchers at the Urban Institute, and these two communities emerged as able to host two-day site visits with the research team.
- ¹⁴ These are federally funded programs designed to help pregnant women and families, particularly those considered at risk, with what they need to raise children who are physically, socially, and emotionally healthy and ready to learn. Home visiting programs seek to improve maternal and child health, prevent child abuse and neglect, encourage positive parenting, and promote child development and school readiness; see “Home Visiting,” Health Resources and Services Administration, accessed February 26, 2020, <https://mchb.hrsa.gov/maternal-child-health-initiatives/home-visiting-overview>.
- ¹⁵ “Opioid Summaries by State,” National Institute on Drug Abuse, accessed February 26, 2020, <https://www.drugabuse.gov/drugs-abuse/opioids/opioid-summaries-by-state>.
- ¹⁶ Some of these perceptions may be partly driven by state policy choices, such as when a state newly decides to cover substance use treatment under Medicaid after initially choosing not to; see Bishop Nash, “Medicaid Now Covering Addiction Services in WV,” *Herald Dispatch* (Huntington, WV), January 17, 2018, https://www.herald-dispatch.com/news/medicaid-now-covering-addiction-services-in-wv/article_0b0be626-9e3b-5bfa-b28e-e3041633880a.html.
- ¹⁷ German Lopez, “The Rehab Racket: Investigating the High Cost of Addiction Care,” *Vox*, accessed February 26, 2020, <https://www.vox.com/2019/9/6/20853284/drug-addiction-treatment-rehab-cost-vox>.
- ¹⁸ “Substance Use Disorders,” Medicaid.gov, accessed February 26, 2020, <https://www.medicaid.gov/medicaid/benefits/behavioral-health-services/substance-use-disorders/index.html>.
- ¹⁹ “Medications to Treat Opioid Use Disorder,” National Institute on Drug Abuse, accessed February 26, 2020, <https://www.drugabuse.gov/publications/research-reports/medications-to-treat-opioid-addiction/efficacy-medications-opioid-use-disorder>. Note that 10 state Medicaid programs do not cover methadone treatment, despite methadone’s inclusion on the World Health Organization’s model list of essential medicines. See “Medicaid Behavioral Health Services: Methadone for Medication Assisted Treatment (MAT),” Henry J. Kaiser Family Foundation, accessed February 26, 2020, <https://www.kff.org/other/state-indicator/medicaid-behavioral-health-services-methadone-for-medication-assisted-treatment-mat/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>; and “WHO Model Lists of Essential Medicines,” World Health Organization, accessed February 26, 2020, <https://www.who.int/medicines/publications/essentialmedicines/en/>.
- ²⁰ Medicaid waivers and programs like Medicaid Health Homes are filling this gap (Clemans-Cope et al. 2017).
- ²¹ Even within each of these systems, there are often powerful rifts and tensions, including those related to coercion, individual rights, new treatment guidelines and protocols, and harm reduction.
- ²² BPC (2019) analyzed how federal opioid investments are being spent across five geographically diverse states: Arizona, Louisiana, New Hampshire, Ohio, and Tennessee.
- ²³ “Safety Organized Practice (SOP),” University of California, Berkeley, California Social Work Education Center, accessed February 27, 2020, <https://calswec.berkeley.edu/toolkits/safety-organized-practice>.
- ²⁴ For more information, visit the Family Recovery Program website, <https://frp-inc.org/>.

- ²⁵ [Fostering Connections to Success and Increasing Adoptions Act of 2008](#), Pub. L. No. 110-351, 122 Stat 3949 (2008).
- ²⁶ [Comprehensive Addiction and Recovery Act of 2016](#), Pub. L. No. 114-198, 130 Stat. 695 (2016).
- ²⁷ “Family Drug Courts: Developing, Enhancing, and Expanding FDCs across the Nation,” Children and Family Futures, accessed February 26, 2020, <https://www.cffutures.org/family-drug-courts-focus/>.
- ²⁸ Rich Lord, “In-Home Drug Counseling Program to Double in Size,” *Pittsburgh Post-Gazette*, December 28, 2018, <https://www.post-gazette.com/news/health/2018/12/28/In-home-drug-counseling-program-to-double-in-size/stories/201812280132>.
- ²⁹ “Family Preservation Services,” Child Welfare Information Gateway, accessed February 26, 2020, <https://www.childwelfare.gov/topics/supporting/preservation/>; Beth Cotez-Neavel, “Substance Use and Family Preservation Services in the Texas Child Welfare System,” *Bethc-n.com*, accessed February 26, 2020, <http://www.bethc-n.com/mental-health-blog/2018/8/11/substance-use-and-family-preservation-services-in-the-texas-child-welfare-system>; “About IFPS,” Intensive Family Preservation Services, accessed February 26, 2020, <http://www.intensivefamilypreservation.org/about/>; “Family Preservation and Substance Abuse,” National Coalition for Child Protection Reform, accessed February 26, 2020, <http://advocatesforpregnantwomen.org/NCCPRPregFactSheet.pdf>; “A Mother-Centered Approach to Treating Neonatal Abstinence Syndrome,” National Institute for Children’s Health Quality, accessed February 26, 2020, <https://www.nichq.org/insight/mother-centered-approach-treating-neonatal-abstinence-syndrome>.
- ³⁰ For more information, see the Positive Behavioral Interventions and Supports website, <https://www.pbis.org/>.
- ³¹ For more information, visit the West Virginia Center for Children’s Justice Handle with Care Program website, <http://www.handlewithcarewv.org/handle-with-care.php>.
- ³² For more information, visit the Botvin LifeSkills Training website, <https://www.lifeskillstraining.com/>.
- ³³ For more information, see the Drug Free Clubs of America website, <https://drugfreeclubs.com/>.
- ³⁴ “Rural Response to the Opioid Crisis,” Rural Health Information Hub, accessed February 26, 2020, <https://www.ruralhealthinfo.org/topics/opioids>.
- ³⁵ “Recovery Friendly Workplace,” Office of New Hampshire Governor Chris Sununu, accessed July 31, 2020, <https://www.recoveryfriendlyworkplace.com/initiative>.
- ³⁶ Jess Aloe, “New Hampshire Pushes Employers to Be ‘Recovery Friendly,’” *AP News*, May 31, 2019, <https://apnews.com/e0ad76123e0a42ccbc97bbeb699567a9>; Lenny Bernstein, “One of the Biggest Challenges of Kicking Addiction Is Getting and Keeping a Job,” *Washington Post*, November 27, 2018, https://www.washingtonpost.com/national/health-science/one-of-the-biggest-challenges-of-kicking-addiction-is-getting-and-keeping-a-job/2018/11/27/87e8a168-d958-11e8-aeb7-ddcad4a0a54e_story.html.
- ³⁷ The National Child Traumatic Stress Network defines a traumatic event as a frightening, dangerous, or violent event that poses a threat to a child’s life or bodily integrity; witnessing a traumatic event that threatens life or physical security of a loved one can also be traumatic, especially for young children, because their sense of safety depends on the perceived safety of their attachment figures. Traumatic experiences include physical, sexual, or psychological abuse and neglect (including trafficking); family or community violence; the sudden or violent loss of a loved one; substance use disorder (personal or familial); serious accidents or life-threatening illness; and military family-related stressors (e.g., deployment, parental loss or injury). See “About Child Trauma,” National Child Traumatic Stress Network, accessed February 26, 2020, <https://www.nctsn.org/what-is-child-trauma/about-child-trauma>.
- ³⁸ “Policy Considerations,” Center for Health Care Strategies, Trauma-Informed Care Implementation Resource Center, accessed July 31, 2020, <https://www.traumainformedcare.chcs.org/policy-considerations/>.

³⁹ For an example of collaborative innovation and learning networks, see the Massachusetts Institute of Technology Center for Collective Intelligence's project, Intelligent Collaborative Knowledge Networks, at <http://www.ickn.org/index.html>.

⁴⁰ For more information on the Addiction Policy Forum's Innovation Now and Spotlight Series, visit <https://www.addictionpolicy.org/solutions>.

⁴¹ For more information on examples of What Works Clearinghouses, visit Washington State Institute for Public Policy at <https://www.wsipp.wa.gov/> and the Child Welfare Information Gateway at <https://www.childwelfare.gov>. Though the National Registry of Evidence-Based Programs and Practices was suspended by the Substance Abuse and Mental Health Services Administration, the program has been replaced by the Evidence-Based Practices Resource Center. For more information, visit <https://www.samhsa.gov/ebp-resource-center/about>.

⁴² "What Is a Shortage Designation?" Health Resources and Services Administration, accessed February 26, 2020, <https://bhw.hrsa.gov/shortage-designation/what-is-shortage-designation>.

References

- Addiction Policy Forum. 2019. Innovative Program Solutions. Accessed February 26, 2020, <https://www.addictionpolicy.org/solutions>.
- AECF (Annie E. Casey Foundation). 2001. *START: A Child Welfare Model for Drug-Affected Families: The Challenge of Drug Abuse in Child Welfare, Part Three*. Baltimore: Annie E. Casey Foundation.
- ASPE (US Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation). 2015. "Opioid Abuse in the US and HHS Actions to Address Opioid-Related Overdoses and Deaths." Washington, DC: US Department of Health and Human Services.
- Attermann, Jeremy, Megan Dormond, and Julia Schreiber. 2017. "Behavioral Health Workforce Implementation Challenges Related to Medication Assisted Treatment." Ann Arbor, MI: University of Michigan Behavioral Health Workforce Research Center.
- Barry, Colleen L., Susan G. Sherman, and Emma E. McGinty. 2018. "Language Matters in Combatting the Opioid Epidemic: Safe Consumption Sites versus Overdose Prevention Sites." *American Journal of Public Health* 108 (9): 1157–59. <https://doi.org/10.2105/AJPH.2018.304588>.
- Bowen, Elizabeth A., and Nadine Shaanta Murshid. 2016. "Trauma-Informed Social Policy: A Conceptual Framework for Policy Analysis and Advocacy." *American Journal of Public Health Perspectives from the Social Sciences* 106 (2): 223–29. <https://doi.org/10.2105/AJPH.2015.302970>.
- BPC (Bipartisan Policy Center). 2019. *Tracking Federal Funding to Combat the Opioid Crisis*. Washington, DC: Bipartisan Policy Center.
- Brundage, Suzanne C., and Carol Levine. 2019. *The Ripple Effect: The Impact of the Opioid Epidemic on Children and Families*. New York: United Hospital Fund.
- Carey, Gemma, Brad Crammond, Eleanor Malbon, and Nic Carey. 2015. "Adaptive Policies for Reducing Inequalities in the Social Determinants of Health." *International Journal of Health Policy and Management* 4 (11): 763–67. <https://doi.org/10.15171/ijhpm.2015.170>.
- Case, Anne, and Angus Deaton. 2017. *Mortality and Morbidity in the 21st Century*. Washington, DC: Brookings Institution.
- Casey Family Programs. 2019. "What Is Connecticut's Family-Based Recovery Program?" Baltimore: Annie E. Casey Foundation.
- Chevarria, Franz, Hugo Inga, Enrica De Pasquale, and Katherine Homberg. 2015. *Public Policy Observatories in the Americas: A Guide for Their Design and Implementation in Our Public Administrations*. Washington, DC: Organization of American States.
- Child Welfare Information Gateway. 2016. Family Preservation Services. Accessed February 26, 2020, <https://www.childwelfare.gov/topics/supporting/preservation/>
- Clemans-Cope, Lisa, Victoria Lynch, Marni Epstein, and Genevieve M. Kenney. 2019. "Opioid and Substance Use Disorder and Receipt of Treatment among Parents Living with Children in the United States, 2015–2017." *Annals of Family Medicine* 17 (3): 207–11. <https://doi.org/10.1370/afm.2389>.
- Clemans-Cope, Lisa, Jane B. Wishner, Eva H. Allen, Nicole Lallemand, Marni Epstein, and Brenda C. Spillman. 2017. "Experiences of Three States Implementing the Medicaid Health Home Model to Address Opioid Use Disorder—Case studies in Maryland, Rhode Island, and Vermont." *Journal of Substance Abuse Treatment* 83:27–35. <https://doi.org/10.1016/j.jsat.2017.10.001>.
- Collier, Lorna. 2018. "Young Victims of the Opioid Crisis." *Monitor on Psychology* 49 (1): 18.

- Collins, Alexandra B., Ricky N. Bluthenthal, Jade Boyd, and Ryan McNeil. 2018. "Harnessing the Language of Overdose Prevention to Advance Evidence-Based Responses to the Opioid Crisis." *International Journal of Drug Policy* 55: 77–79. <https://doi.org/10.1016/j.drugpo.2018.02.013>.
- Council of Economic Advisers. 2017. "The Underestimated Cost of the Opioid Crisis." Washington, DC: Executive Office of the President of the United States.
- Csete, Joanne, Adeeba Kamarulzaman, Michel Kazatchkine, Frederick Altice, Marek Balicki, Julia Buxton, Javier Cepeda, et al. 2016. "Public Health and International Drug Policy." *Lancet* 387 (10026): 1427–80. [https://doi.org/10.1016/S0140-6736\(16\)00619-X](https://doi.org/10.1016/S0140-6736(16)00619-X).
- Dasgupta, Nabarun, Leo Beletsky, and Daniel Ciccarone. 2018. "Opioid Crisis: No Easy Fix to Its Social and Economic Determinants." *American Journal of Public Health* 108 (2): 182–86. <https://doi.org/10.2105/AJPH.2017.304187>.
- Dormond, Megan. 2017. "Scope of Practice Alignment with Job Tasks for Paraprofessionals and Addiction Counselors." Ann Arbor, MI: University of Michigan Behavioral Health Workforce Research Center.
- Florence, Curtis S., Chao Zhou, Feijun Luo, and Likang Xu. 2016. "The Economic Burden of Prescription Opioid Overdose, Abuse, and Dependence in the United States, 2013." *Medical Care* 54 (10): 901–06. <https://doi.org/10.1097/MLR.0000000000000625>.
- Freundlich, Madelyn. 2010. *Legislative Strategies to Safely Reduce the Number of Children in Foster Care*. Washington, DC: National Conference of State Legislatures.
- Gaither, Julie R., Veronika Shabanova, and John M. Leventhal. 2018. "US National Trends in Pediatric Deaths from Prescription and Illicit Opioids, 1999–2016." *JAMA Network Open* 1 (8): e186558. <https://doi.org/10.1001/jamanetworkopen.2018.6558>.
- Gallagher, Romyne. 2018. "Opioid-Related Harms: Simplistic Solutions to the Crisis Ineffective and Cause Collateral Damage." *Health Services Insights* 11: 1–3. <https://doi.org/10.1177/1178632918813321>.
- Ghertner, Robin, Melinda Baldwin, Gilbert Crouse, Laura Radel, and Annette Waters. 2018. "The Relationship between Substance Use Indicators and Child Welfare Caseloads." Washington, DC: US Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation.
- Gomes, Tara, Mina Tadrous, Muhammad M. Mamdani, Michael Paterson, and David N. Juurlink. 2018. "The Burden of Opioid-Related Mortality in the United States." *JAMA Network Open* 1 (2): e180217. <https://doi.org/10.1001/jamanetworkopen.2018.0217>.
- Green-Hennessy, Sharon. 2018. "Suspension of the National Registry of Evidence-Based Programs and Practices: The Importance of Adhering to the Evidence." *Substance Abuse Treatment, Prevention, and Policy* 13 (1). <https://doi.org/10.1186/s13011-018-0162-5>.
- Hagemeyer, Nicholas E. 2018. "Introduction to the Opioid Epidemic: The Economic Burden on the Healthcare System and Impact on Quality of Life." *American Journal of Managed Care* 24 (10 Suppl.): S200–S206.
- Haskins, Julia. 2019. "Suicide, Opioids Tied to Ongoing Fall in US Life Expectancy: Third Year of Drop." *Nation's Health* 49 (1): 1–10.
- Heffernan, Kristin, and Pamela Viggiani. 2015. "Going Beyond Trauma Informed Care (TIC) Training for Child Welfare Supervisors and Frontline Workers: The Need for System Wide Policy Changes Implementing TIC Practices in All Child Welfare Agencies." *Advanced Generalist: Social Work Research Journal* 1 (3/4): 37–58.
- Kiang, Matthew V., Sanjay Basu, Jarvis Chen, and Monica J. Alexander. 2019. "Assessment of Changes in the Geographical Distribution of Opioid-Related Mortality across the United States by Opioid Type, 1999–2016." *JAMA Network Open* 2 (2): e190040. <https://doi.org/10.1001/jamanetworkopen.2019.0040>.
- Kocherlakota, Prabhakar. 2014. "Neonatal Abstinence Syndrome." *Pediatrics* 134 (2): e547–e561. <https://doi.org/10.1542/peds.2013-3524>.

- Lander, Laura, Janie Howsare, and Marilyn Byrne. 2013. "The Impact of Substance Use Disorders on Families and Children: From Theory to Practice." *Social Work in Public Health* 28 (3-4): 194–205. <https://doi.org/10.1080/19371918.2013.759005>.
- Lipari, Rachel N., Eunice Park-Lee, and Struther L. Van Horn. 2016. *America's Need for and Receipt of Substance Use Treatment in 2015*. Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Lipari, Rachel N., and Struther L. Van Horn. 2017. *Children Living with Parents Who Have a Substance Use Disorder*. Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Mechanic, David. 2017. "Coming Problems in Behavioral Health Care." *Milbank Quarterly* 95 (2): 233–36. <https://doi.org/10.1111/1468-0009.12256>.
- National Advocates for Pregnant Women. 2018. "Understanding CAPTA and State Obligations." New York: National Advocates for Pregnant Women.
- Normile, Becky, Carrie Hanlon, and Hannah Eichner. 2018. "State Strategies to Meet the Needs of Young Children and Families Affected by the Opioid Crisis." Washington, DC: National Academy for State Health Policy.
- Nosrati, Elias, Jacob Kang-Brown, Michael Ash, Martin Mckee, Michael Marmot, and Lawrence P. King. 2019. "Economic Decline, Incarceration, and Mortality from Drug Use Disorders in the USA between 1983 and 2014: An Observational Analysis." *Lancet Public Health* 4 (7): e326–e333. [https://doi.org/10.1016/S2468-2667\(19\)30104-5](https://doi.org/10.1016/S2468-2667(19)30104-5).
- Office of the Surgeon General. 2016. "Chapter 6: Health Care Systems and Substance Use Disorders." In *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health*. Washington, DC: US Department of Health and Human Services, Office of the Surgeon General.
- Orgera, Kendal, and Jennifer Tolbert. 2019. "The Opioid Epidemic and Medicaid's Role in Facilitating Access to Treatment." San Francisco: Henry J. Kaiser Family Foundation.
- Peters, Rebecca, and Erik Wengle. 2016. "Coverage of Substance-Use Disorder Treatments in Marketplace Plans in Six Cities." Washington, DC: Urban Institute.
- Pullen, Erin, and Carrier Oser. 2014. "Barriers to Substance Abuse Treatment in Rural and Urban Communities: Counselor Perspectives." *Substance Use and Misuse* 49 (7): 891–901. <https://doi.org/10.3109/10826084.2014.891615>.
- Radel, Laura, Melinda Baldwin, Gilbert Crouse, Robin Ghertner, and Annette Waters. 2018. "Substance Use, the Opioid Epidemic, and the Child Welfare System: Key Findings from a Mixed Methods Study." Washington, DC: US Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation.
- Ringel, Jeanne S., Dana Schultz, Joshua Mendelsonn, Stephanie Brooks Holliday, Katharine Sieck, Ifeanyi Edochie, and Lauren Davis. 2017. *Improving Child Welfare Outcomes: Balancing Investments in Prevention and Treatment*. Santa Monica, California: RAND Corporation.
- Roberts, Dorothy E. 1999. "The Challenge of Substance Abuse for Family Preservation Policy." Faculty Scholarship Paper 591. Philadelphia: University of Pennsylvania Law School.
- Romanowicz, Magdalena, Jennifer L. Vande Voort, Julia Shekunov, Tyler S. Oesterle, Nuria J. Thusius, Teresa A. Rummans, Paul E. Croarkin, Victor M. Karpyak, Brian A. Lynch, and Kathryn M. Schak. 2019. "The Effects of Parental Opioid Use on the Parent-Child Relationship and Children's Developmental and Behavioral Outcomes: A Systematic Review of Published Reports." *Child and Adolescent Psychiatry and Mental Health* 13 (5). <https://doi.org/10.1186/s13034-019-0266-3>.
- SAMHSA (Substance Abuse and Mental Health Services Administration Office of Policy, Planning, and Innovation). 2014. *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

- Sawyer, Donald, John A. Gale, and David Lambert. 2006. "Rural and Frontier Mental and Behavioral Health Care: Barriers, Effective Policy Strategies, Best Practices." Washington, DC: National Association of Rural Mental Health.
- Scholl, Lawrence, Puja Seth, Mbabazi Kariisa, Nana Wilson, and Grant Baldwin. 2019. "Drug and Opioid-Involved Overdose Deaths—United States, 2013–2017." *Morbidity and Mortality Weekly Report* 67 (5152): 1419–27. <http://dx.doi.org/10.15585/mmwr.mm675152e1>
- Seibert, Julie, Holly Stockdale, Rose Feinberg, Erin Dobbins, Elysha Theis, and Sarita L. Karon. 2019. *State Policy Levers for Expanding Family-Centered Medication-Assisted Treatment*. Prepared for the US Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. Washington, DC: RTI International.
- Serafini, Marilyn. 2018. "The Physicians' Quandary with Opioids: Pain versus Addiction." *New England Journal Medicine Catalyst*.
- Smedley, Brian D., Adrienne Y. Stith, and Alan R. Nelson. 2003. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Washington, DC: National Academies Press.
- Solis, Jessica M., Julia M. Shadur, Alison R. Burns, and Andrea M. Hussong. 2012. "Understanding the Diverse Needs of Children Whose Parents Abuse Substances." *Current Drug Abuse Reviews* 5 (2): 135–47. <https://doi.org/10.2174/1874473711205020135>.
- Stuber, Jennifer, Ilan Meyer, and Bruce Link. 2008. "Stigma, Prejudice, Discrimination, and Health." *Social Science and Medicine* 67 (3): 351–57. <https://doi.org/10.1016/j.socscimed.2008.03.023>.
- Tilson, Elizabeth Cuervo. 2018. "Adverse Childhood Experiences (ACEs): An Important Element of a Comprehensive Approach to the Opioid Crisis." *North Carolina Medical Journal* 79 (3): 166–69. <https://doi.org/10.18043/ncm.79.3.166>.
- VanHouten, Jacob P., Rose A. Rudd, Michael F. Ballesteros, and Karin A. Mack. 2019. "Drug Overdose Deaths among Women Aged 30–64 Years—United States, 1999–2017." *Morbidity and Mortality Weekly Report* 68 (1): 1–5. <http://dx.doi.org/10.15585/mmwr.mm6801a1>.
- Volkow, Nora D., Vladimir Poznyak, Shekhar Saxena, and Gilberto Gerra. 2017. "Drug Use Disorders: Impact of a Public Health Rather Than a Criminal Justice Approach." *World Psychiatry: Official Journal of the World Psychiatric Association* 16 (2): 213–14. <https://doi.org/10.1002/wps.20428>.
- Wakeman, Sarah E. 2017. "Medications for Addiction Treatment: Changing Language to Improve Care." *Journal of Addiction Medicine* 11 (1): 1–2. <https://doi.org/10.1097/ADM.0000000000000275>.
- Zhang, Jing, Natasha Slesnick, and Xin Feng. 2017. "Co-Occurring Trajectory of Mothers' Substance Use and Psychological Control and Children's Behavior Problems: The Effects of a Family Systems Intervention." *Family Process* 57 (1): 211–25. <https://doi.org/10.1111/famp.12279>.

About the Authors

Laudan Y. Aron is a senior fellow in the Health Policy Center at the Urban Institute. Since joining Urban in 1992, she has spent over 25 years conducting research and policy analysis on a wide range of social welfare issues, including health and disability, education, employment and training, homelessness, and family violence. She directed and coedited a ground-breaking 2013 study for the National Research Council and Institute of Medicine on *US Health in International Perspective: Shorter Lives, Poorer Health*, which found a large and growing US “health disadvantage” relative to other high-income countries. Her work focuses on how social and economic conditions shape health and well being, and how social welfare programs (broadly defined) can best support healthy human development across the life course and over time and place.

Throughout her career, Aron has conceptualized, designed, and fielded studies that are of greatest use to policymakers, program officials, and other interested stakeholders. Her many publications include books, book chapters, journal articles, and opinion pieces on topics ranging from social determinants of health to urban education reform. From 2007 to 2012, she served as a senior program officer with the Division of Behavioral and Social Sciences and Education at the National Academy of Sciences, and as director of policy research at the National Alliance on Mental Illness.

Aron holds a BS in mathematics from McGill University and an MA in demography from the University of Pennsylvania.

Sarah Benatar is a principal research associate in the Health Policy Center. Her research investigates how public policies affect vulnerable populations’ health outcomes, access to care, use of services, and enrollment in coverage programs, with a particular focus on maternal and child health.

Benatar has led and participated in several projects focused on maternal and child health, the Children’s Health Insurance Program, and Medicaid, combining qualitative and quantitative methods to achieve the richest findings. She is working on a national evaluation of the Centers for Medicare and Medicaid Services’ Strong Start for Mothers and Newborns enhanced prenatal care program; she leads the evaluation’s process measurement and monitoring task and is a senior member of the case study team. Benatar is also deputy project director for a multiyear evaluation of a home visitation and community-based program intervention in Los Angeles, aimed at improving health and developmental outcomes for low-income mothers and children. She is coleading a study to examine the impact of the Affordable Care Act on women’s preventive health care service use.

Additional recent work includes an evaluation of ongoing efforts to redesign the county clinic system in San Mateo County, California, an evaluation of a physician incentive program in Los Angeles, a review of recent family planning research, and a feasibility assessment of a universal vaccine-purchasing program for children in New York State.

Benatar holds a PhD in public policy from George Washington University.

Rebecca Peters is a former research associate in the Health Policy Center, where her qualitative and quantitative research focused on the impacts of the Affordable Care Act, innovation in health care delivery, access to health care, health care disparities, and measuring and improving quality of care for children and underserved populations.

STATEMENT OF INDEPENDENCE

The Urban Institute strives to meet the highest standards of integrity and quality in its research and analyses and in the evidence-based policy recommendations offered by its researchers and experts. We believe that operating consistent with the values of independence, rigor, and transparency is essential to maintaining those standards. As an organization, the Urban Institute does not take positions on issues, but it does empower and support its experts in sharing their own evidence-based views and policy recommendations that have been shaped by scholarship. Funders do not determine our research findings or the insights and recommendations of our experts. Urban scholars and experts are expected to be objective and follow the evidence wherever it may lead.



500 L'Enfant Plaza SW
Washington, DC 20024

www.urban.org