The Effects of Parental Substance and Opioid Use:

Parent and Provider Perspectives

Thesis

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Abstract

As rates of opioid abuse and opioid overdose related deaths have risen in the nation, the need for information to fight this epidemic has risen in tandem (Center for Disease Control [CDC]), 2018). In this thesis, the author attempts to further the general understanding of how parental opioid and substance abuse affects children. Secondary analysis was conducted on two sets of unpublished data, each related to the impact of parental opioid and substance abuse on children. The first data set included parent responses to a Strengths and Difficulties Questionnaire (SDQ) from the Ohio START (Sobriety, Treatment, and Reducing Trauma) survey, and demographic information about the parent and child. The second data set was a transcription of seven focus groups in which Ohio Domestic Violence Network (ODVN) providers discussed questions about how they had seen opioid use affect children. The first data showed significant differences between some age groups and races in the sub-sets of the SDQ. However, none of the average results showed abnormal scores, total score nor sub-score. In the focus groups, three theme categories emerged: *Child Maltreatment*, *Action over Children*, and *Behavior Changes*. In conclusion, due to the differing aims of the original studies a clear comparison between the data could not be made. Further research should be conducted with Ohio START data to address how parental opioid and substance abuse is affecting children; the sub-themes of intrafamilial human-trafficking and kinship care of a child as a result of parental opioid and substance abuse that emerged from the focus groups should also be investigated.

Dedication

This thesis is dedicated to all of the children affected by the opioid epidemic. Hopefully, as we learn more about opioid use these children and their families will find healing.

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First, I would like to thank my advisors, Susan Yoon and Cecilia Mengo. Under their guidance I have been able to learn the basics of research, and exponentially grown both academically and professionally. I would also like to thank my husband, Zach. His undying support has helped me through the toughest moments of this thesis. And finally, I am incredibly grateful to the College of Social Work at Ohio State for providing me with the opportunity to complete an honors thesis.

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Fields of Study

Major Field: Social Work

Minor Field: Child Abuse and Neglect

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Statement of Research Topic

Problem Statement

The United States is facing an opioid epidemic. Everyday 130 Americans die due to an opioid related overdose (CDC, 2018). Over the past twenty years the United States has seen a dramatic rise in opioid use. The rates from 2000 to 2014 increased by 200% and continue to rise. Between 2016 and 2017 the rate of opioid overdoses rose 9.6% nationwide (CDC, 2018). In Ohio, the rates rose 18.4% nearly double the national average (CDC, 2018). This increase is in part due to the amount of opioid prescribed. Ohio doctors prescribe 100 prescriptions per 100 people in Ohio (CDC, 2014). That means that there are enough opioid prescriptions for every man, woman, and child to have one. With the increase of opiate substance abuse, the effects on the maltreatment of children need to be studied and documented.

Purpose of Study

This study aims to advance the collective understanding of the impact of parental opioid and substance abuse on children, including the current effect of the current opioid crisis. There are many studies dedicated to understanding how parental substance abuse affects children (Famularo et al., 1992; Kepple, 2017). This study hopes to bolster previous standing research, while providing more insight to both parental substance abuse at large and parental opioid abuse. This study aims to explore the mental and behavioral health outcomes of children who are affected by parental opioid and substance use. Using two secondary datasets, this study will investigate the relationship between parental opioid and substance use and mental and behavioral health outcomes of their children. More specifically, the study aims to investigate children's mental and behavioral health outcomes through the lens of parents who are currently

participating in the Ohio START (Sobriety, Treatment, and Reducing Trauma) program, as well as through the lens of Ohio Domestic Violence Network (ODVN) service providers.

Research Questions

Question 1: How are children's developmental mental and behavioral health outcomes impacted by parental opioid abuse from the perspective of ODVN service providers?

Question 2: How does parental substance abuse affect children's mental and behavioral health outcomes according to the Strengths and Difficulties Questionnaire (SDQ)?

Literature Review

Opioid Epidemic

Populations Most Affected

The most recent opioid epidemic began in the middle class and the most affected populations are adolescents, women, and people who are white (American Society of Addiction Medicine [ASAM], 2016; Mendoza et al., 2019). Teenagers are not prescribed the heavy painkillers as often as adults, but if they are in enough pain adults who do not understand the dangerous nature of opioids will share their prescription to help the teen (ASAM, 2016). Unfortunately, this act has been found to lead to increased adolescent opioid dependence (ASAM, 2016). Women are more likely to be affected by the opioid epidemic because they are more frequently prescribed opiates to manage pain than men and are also more likely to become addicted (ASAM, 2016).

History

The epidemic began with an over prescription for long term pain management in the 1990's. Drugs like oxycontin were promoted as having little to no side effects and no risk of addiction, but by the turn of the millennium there was significant spike in prescription opioid

overdose deaths (CDC, 2018). Prescription opioid dependence then led to an increase of opioid sales and by 2010 there was an increase of heroin related deaths (CDC, 2018). Opioids come in three main forms: prescription, heroin, and synthetic. Prescription opioids often begin as a legitimate prescription to manage short term pain, but due to their addictive nature even over a short time people become addicted and abuse the prescription. This addiction can be very strong and those who become addicted often turn to heroin. Heroin is an illegal opiate that is cheaper and easier to obtain than prescription opioids. Four out of five people addicted to heroin were first addicted to prescription opiates (ASAM, 2016). Synthetic opiates, such as fentanyl, are extremely potent and dangerous. Traces of synthetic opiates are often found in heroin. Synthetic opiates are the most recent to rise in popularity of use. Due to this there are few statistics about the demographics specifically affected by synthetic opiates. Most recently, over the last six years, there has been an extremely sharp increase of synthetic opioid deaths. So much so that the most common opioid overdose involves a synthetic opioid (CDC, 2018). At this time all types of opioid overdoses are rising.

Even in this tragic situation, it is important to recognize that the Opioid Epidemic is steeped in racial disparity. Sometimes referred to as the "White Opioid Epidemic," the current national crisis is affecting more people who are white than people of color (Mendoza et al., 2019). Similar addiction crisis have been seen in communities of people of color, however the narrative has been criminalizing and blaming towards these minority groups, in comparison to the current narrative of the opioid epidemic that paints opioid addiction as a disease and blames the pharmaceutical companies and not the people who are addicted to opioids (Mendoza et al., 2019). Along with these leading narratives, it has been shown that people who are white often have a higher pain tolerance and are therefore more less likely to suffer chronic pain, but they are

more likely to seek out or receive medication to cope with this pain than people of color (Wyatt, 2013). People of color on the other hand, have a much more difficult time accessing prescription opioids because there is a false stereotype that they are more likely to abuse them than people who are white (along with other barriers to accessing resources such as lack or transportation, discrimination, etc.), even though they may actually need prescription opioids more than people who are white (Wyatt, 2013).

Effects of Parental Opioid Use

There are varying reports about how many parents die from an opioid overdose, but as the Opioid Epidemic has continued to take lives, tens of thousands of more children have been placed in foster and kinship care since 2010 (Children's Bureau, 2018). Being placed in a new environment, often separated from all they have ever known, children often experience severe trauma that affects their well-being. Unable to have a constant parent figure, a child may, "not form an attachment to anyone… and [show] little feeling toward his parents when they visit" (Yarrow, 1964). This detachment from caregivers has a negative impact on a child's emotional and mental health. However, this thesis endeavors to show that this trauma is only one of many ways that the opioid epidemic affects children.

While there is little information about how opioid abuse affects children while in the care of a guardian using opioids- there is a lot of information about how they are affected by other addictions. In those cases, research has established that there are negative effects on the child's physical and mental health, partially due to heightened risk of child maltreatment in children whose parents abuse drugs (Romanowicz et al., 2019). This thesis discusses how children's outcomes vary from parents that abuse opiates and parents that generally abuse substances.

Substance Abuse

National and Local Statistics In the United States substance use can be grouped into three categories, illicit drugs, alcohol, and tobacco. When the Substance Abuse and Mental Health Services Administration created a report about children that have parents with a substance use disorder (SUD) they only reported SUDs "related to their use of alcohol or illicit drugs" (Lipari & Van Horn (2017). So, for the purpose of this study, statistics about illicit drug use and alcohol use will be explored. Illicit drug use is defined by the National Institute on Drug Abuse (NIDA) as, "use of illegal drugs, including marijuana according to federal law, and misuse of prescription drugs" (2015). It is estimated that in the year of 2017 374,364,000 people ages 12 or older in United States used illicit drugs (Substance Abuse and Mental Health Services Administration [SAMHSA], 2020). Some 7,819,000 people were diagnosed with a drug use disorder in the United States in the year of 2017 (SAMHSA, 2020). While these figures are only the best estimates about illicit drug use and addiction in our country, it is clear it is no small issue. In Ohio alone it is estimated 11,796,000 people used illicit drugs in 2017, and 319,000 were diagnosed with an illicit drug use disorder (SAMHSA, 2020).

Although alcohol is legally available to adults over the age of 21 in the United States, the misuse of alcohol can have devastating results for an individual and their family. In 2017 it is estimated that 14,661,000 people in the United States have been diagnosed with an alcohol use disorder (SAMHSA, 2020). In Ohio, the corresponding estimate that year was 505,000 individuals (SAMHSA, 2020).

Effect of Parental Substance Use

When a parental substance abuse occurs, there is a much higher chance of child maltreatment (Walsh et al., 2003). Child maltreatment is the overarching term that is used to describe both physical abuse and neglect. When maltreatment occurs, it causes major delays in a

child's development both mentally and physically. This is especially important to note because when parents abuse substances the instances of social worker substantiated abuse double (Freisthler et al., 2017). In a recent study of adolescent health, Dir et al., found that adolescents who had a parent with an opioid use disorder are more likely to experience physical and verbal abuse that an adolescent with a father who has a different substance use disorder (2019). However, all adolescents who have a parent that has a substance use disorder are more likely to experience traumatic violence (Dir et al., 2019).

Depending on the type of drug that is used and the frequency of use each family's experience will differ. Generally, there are cycles of abuse and rehabilitation that parent will go through, throughout their addiction. Times of rehabilitation tend to be safer and less traumatic for children (Barnard & McKeganey, 2003). Little is known about how parental opioid abuse specifically plays a role in child maltreatment; however, it is known that it has an effect on the physical and mental wellness of the children.

One of the biggest problems with parental opioid abuse it that too high of a dose will cause the parent to be left unconscious and unable to care for their child. When a child is neglected, they are left to fend for themselves (Mirick & Steenrod, 2016). This causes an extreme risk for infants and small children because they are unable to feed, cloth, wash, or identify danger for themselves. The inability of small children to feed themselves will lead to malnourishment and vitamin or nutrient deficiencies that can weaken the immune system, making the child more susceptible to illness. Malnourishment can also permanently stunt a child's growth, which can lead to other health problems.

Neglect also leads to accidents that may not have occurred otherwise. An infant may roll off a couch or a hungry toddler may try to use the stove without supervision. Neglect does not

affect adolescents in the same physical way as younger children. However, it can deeply affect parts of their mental health.

Beatings also have the ability to leave children with severe physical damage. This, of course, depends on the type of injury and the stature of the child. It is easier for younger children to become more seriously injured by a parent or caregiver. Much like neglect, some of the worst wounds that an adolescent would suffer from physical abuse are the mental and emotional scars that they will carry with them the rest of their lives. Physical abuse causes children of all ages extreme stress. When the abuse is consistently given it causes children's stress response to remain active. This leads to heightened cortisol levels, which cause anxiety, depression, heart disease, sleep problems, weight gain, and memory and concentration impairment (Mayo Clinic Staff, 2019).

On a more hopeful note, Slesnick et al., found that mothers who are addicted to opioids have fewer negative parenting behaviors than mothers who are addicted to alcohol and are less aggressive than mothers who are addicted to cocaine (2014). This data is not conclusive, but it does help to identify some of the strengths that mothers who use opioids have.

Just how child maltreatment stunts physical development, it will also delay mental and emotional growth. This may be further upsetting to the caregiver that it can lead to more abuse because the child may not be able to follow directions, clean up after themselves, or communicate with others in a way that one would deem age appropriate. Some may also suffer delays in their learning. This typically shows through poor grades, needing to repeat a grade, and being placed in special education programs (Peisch et al., 2018). Being behind their peers can instill feelings of worthlessness and shame in even some of the youngest of students. When prolonged and

internalized these feelings have the ability to lend to the development of depression and anxiety in a young child's mind.

More recent studies have also shown a rise of Post-Traumatic Stress Disorder (PTSD) in young children (De Young & Scheeringa, 2018). This disorder once thought to only affect adults who have experienced the violence of war in now used to describe the mental state of children who have suffered abuse and neglect. Often emotional or mental delays show themselves through inappropriate behavior. These are often diagnosed as Oppositional Defiant Disorder and Attention Deficit Hyperactivity Disorder (Wilens et al., 2002). However, some more recent studies have found that there is an over diagnosis of behavioral disorders in youth.

Methods

Research design

The proposed study is a secondary data analysis of existing data from two original studies, The Ohio START Survey and Building recommended practices for working with domestic violence survivors who use opioids in residential services: A community engagement approach. This is a mixed methods study as the original studies are quantitative research and qualitative research, respectively. Quantitative data was be received from the Ohio START Survey study. The Ohio START Survey data was collected via phone interviews. While, qualitative data was received from the Building recommended practices for working with domestic violence survivors who use opioids in residential services: A community engagement approach study. The data from this study was collected by a series of focus groups discussions held with ODVN service providers.

Sample

The Ohio START survey is given to adults (age 18+) who are participants in the Ohio START program. Due to the nature of the Ohio START program, all participants are parents who have been involved with the child-welfare system due to substance-misuse related child maltreatment. Participants for this survey are from central and southern counties of Ohio, including: Athens, Brown, Clinton, Fairfield, Fayette, Franklin, Gallia, Hamilton, Highland, Hocking, Jackson, Lawrence, Meigs, Pickaway, Ross, Vinton, and Warren. The study sample size is 44 participants.

The focus groups about the effect of opioid use on children of survivors of DV was made up of service providers (both administrative and frontline workers) from the Ohio Domestic Violence Network (ODVN). The service providers are all adults (age 18+). Seven focus groups took place to address the experience of the ODVN's five regional agencies (Central, Southeast, Southwest, Northeast, and Northwest). At least six service providers participated in each focus group with a total of 55 service providers in participation.

Measurement/Instrumentation

The following measurements were used to assess the constructs of interest.

Table 1. Key measurement tools and descriptions

Constructs	**Measures**	**Description**
Child mental and behavioral problems (parental substance abuse)	Strengths and Difficulty Questionnaire (SDQ)	SDQ: 25 items; 5 subscales: emotional symptoms, conduct problems, hyperactivity/inattention, peer relation problems, prosocial behavior. [for children 2-17yrs]
Child mental and behavioral problems (parental opioid abuse)	Focus Group with ODVN service providers	Service providers are made up of both administrative and frontline workers. The initial focus group consisted of 55 questions. The proposed study will

Constructs	Measures	Description
		include two questions posed in the focus group: "How has opioid use impacted the children in your residential services?" and (in regard to parental overdose) "How did the overdose impact children in services?"
Child demographics	3-item survey reported by parent	These three items include the child's birthdate, the child's race and ethnicity, and the child's gender

Detailed Data Collection Procedures

As a secondary data analysis, the proposed study will not collect any new data. The data collection procedures that follow are those that were followed by the initial studies.

Ohio START Survey

The Ohio START survey research team receives the contact information of the participants from the county through which they receive Ohio START services on a password protected document via e-mail. Before sending the contact information the Ohio START caseworker briefly explains the purpose of the Ohio START survey and asks if the participant would be interested in participating in the survey. Once the contact information is received a research assistant copies the information from the e-mail to a comprehensive list of all Ohio START participants that have been sent to the Ohio START research team. The participants are then contacted via phone or text to do a 30-45-minute interview. After phone contact is made a verbal consent script is read. This script includes the purpose of the study, the study compensation, risk of breach of confidentiality, the intent to conduct a follow up study in six months, and the contact information for the principle investigator of the study as well as the

contact information of the Office of Responsible Research Practices. If the participant gives their consent, the research assistant will continue with the survey. The survey was made up of six sections that covered: protective factors, parental experiences, child development, service accessibility, mental/behavioral health services for the child, and demographics. The participants are compensated for their time with a $25 gift card, as well as for phone minutes (if necessary). Once the interview is completed the responses are stored securely until they are entered in a Qualtrics study database.

Building recommended practices for working with domestic violence survivors who use opioids in residential services: A community engagement approach

ODVN service providers, both frontline and administrative personnel, participated in focus groups mediated by an IRB approved research staff member. Before the focus group begins, the mediator allowed the service providers the opportunity to sign a consent form as well as gave verbal consent before the session begins. Prior to focus group participation, OSU researchers provided a training to study staff which concentrated on techniques of facilitation of group interaction, discussion and asking questions. A second research staff acted as an on-site observer; as such, they did not participate in the discussion and was unobtrusively situated to record field notes. Field notes indicated key points of discussion, significant quotes, behavioral observations such as body language, irony, etc. In addition, all focus group sessions were audio taped. Focus groups audio-recording began after consent, and focus group participants were notified when audio recording was beginning and ending. Focus group discussions lasted between 90 and 180 minutes. Light refreshments and lunch were served during focus groups.

Data Analysis

With the Ohio START survey data, univariate descriptive analysis were conducted with the demographic information and the SDQ scores. These univariate descriptives include mean, standard deviation, minimum, maximum, and percentages. These provide a clear picture of the data from the Ohio START Survey. In order to reach the study aims, bivariate analysis was conducted. A Pearson correlation was done with the parent age at the child's birth and the child's SDQ score. Two t-tests were performed; one with SDQ scores and gender of the children and another with the SDQ scores and race of the children. Finally, a one-way ANOVA was conducted with the SDQ scores and the ages of the children.

In order to address the research aims and answer the proposed research questions, thematic analysis was done of the specified questions of the ODVN focus groups. First, the interviews of all seven groups were reviewed and the sections allowed to be used through International Review Board (IRB) approval were put into a separate file. The new file was then coded in its entirety. Then, the coding was reviewed a second time. Codes were then categorized into themes. Themes were then categorized into theme categories for further clarity. Thematic analysis allowed for a thorough investigation of the information provided by the service providers that participated in the focus group.

Results

Ohio START Survey

Forty-four parents completed pre-test surveys about the Ohio START program. The average age of the parent completing the survey was 31.7 years old with a standard deviation of 5.33, with a minimum of 21 years and a maximum of 43 years (*r*=22). When the child reported on was born the average age of the parent was 25.5 years old with a standard deviation of 4.94, and a minimum of 18 years and a maximum of 38 years (*r*=20). When considering parental education, 27.3% of parents completed some high school (*n*=12), 40.9% received a high school diploma or GED (*n*=18), 2.3% had trade/vocational training (*n*=1), 15.9% had some college (*n*=7), 6.8% completed a 2-year college degree (*n*=3), and 6.8% completed a 4-year college degree (*n*=3).

The average age of the children reported on is 6.2 years old with a standard deviation of 3.72, with a minimum of 0 years and a maximum of 15 years (*r*=15). Of the children, 56.8% were male (*n*=25) and 43.2% were female (*n*=19). Race and ethnicity show that 77.3% of the children were identified to be White (*n*=34), 4.5% were identified to be Black or African-American (*n*=2), 2.3% were identified to be Asian or Pacific Islander (*n*=1), 6.8% were identified to be Multi-racial (*n*=3), and 9.1% were identified as Other (*n*=4). This can also be viewed in terms of White (77.3%, *n*=34) and Non-White (23.7%, *n*=10) children. Table 2 summarizes sample characteristics.

Table 2

Sample Characteristics

Variable	*M (SD)*	Min.	Max.	*n*	%
Child Age	6.2 (3.72)	0	15	44	
Parent Age	31.7 (5.33)	21	43	44	
Parent Age at Child's Birth	25.5 (4.94)	18	38	44	
Child Gender					
Male				25	56.8
Female				19	43.2
Child Race					
White				34	77.3
Black or African American				2	4.5
Asian or Pacific Islander				1	2.3
Multi-racial				3	6.8
Other				4	9.1
Parent Highest Level of Education					
Some High School				12	27.3
High School Diploma or GED				18	40.9
Trade/Vocational Training				1	2.3
Some College				7	15.9
2-year College Diploma				3	6.8
4-year College Diploma				3	6.8

The Strengths and Difficulties Questionnaire (SDQ) has five subcategories, allowing for a total score of 50 points. However, in this table the difficulties score is shown. The difficulties score is found by adding the score of all of the subcategories, except for the prosocial category (which is considered to be a strengths category), allowing for a total score of 40. That being said, the SDQ difficulties scores showed an average of 9.9 points with a standard deviation of 5.63, and a minimum of 1 point and a maximum of 30 points (r=29). The emotional symptoms subcategory score showed an average of 1.8 points with a standard deviation of 1.75, and a minimum of 0 points and a maximum of 6 points (r=6). The conduct problems subcategory score showed an average of 2.4 points with a standard deviation of 1.74, and a minimum of 0 points and a maximum of 8 points (r=8). The hyperactivity/inattention subcategory score showed an average of 4.3 points with a standard deviation of 2.62, and a minimum of 0 points and a maximum of 10 points (r=10). The peer relations problems subcategory score showed an average of 1.4 points with a standard deviation of 1.63, and a minimum of 0 points and a maximum of 7 points (r=7). The prosocial behavior subcategory score showed an average of 8.1 points with a standard deviation of 1.81, and a minimum of 3 points and a maximum of 10 points (r=7).

Table 3

Descriptives for the Strengths and Difficulties Questionnaire (SDQ) Scores (n=44)

Variable	*M (SD)*	Min.	Max.
SDQ Difficulties Score	9.9 (5.63)	1	30
Emotional Symptoms	1.8 (1.75)	0	6
Conduct Problems	2.4 (1.74)	0	8
Hyperactivity/Inattention	4.3 (2.62)	0	10
Peer Relation Problems	1.4 (1.63)	0	7
Prosocial Behavior	8.1 (1.81)	3	10

To see if there was a statistically significant correlation between the parent age at the time of the child's birth and child outcomes, a correlation was computed. The assumptions of normality were met by the parent age at the child's birth and the SDQ scores. Therefore, a Pearson Correlation was used. No statistically significant correlation was found between the SDQ scores and the parent age at the time of the child's birth (see Table 4).

Table 4

Pearson Correlation of Parent Age at Child's Birth and SDQ Scores

Variable	1	2	3	4	5	6	7
1. Parent Age at Child's Birth	--	-0.06	-0.21	-0.02	-0.14	0.03	-0.13
2. Emotional Symptoms	--	--	0.24	0.27	0.33*	-0.26	0.61**
3. Conduct Problems	--	--	--	0.45**	0.63**	-0.33*	0.78**
4.Hyperactivity/Inattention	--	--	--	--	0.30	-0.45**	0.78**
5. Peer Relation Problems	--	--	--	--	--	-0.30*	0.72**
6. Prosocial Behavior	--	--	--	--	--	--	-0.48**
7. SDQ Difficulties Score	--	--	--	--	--	--	--

**Correlation is significant at the 0.05 level (2-tailed)*
***Correlation is significant at the 0.01 level (2-tailed)*

Table 5 shows that there is not a significant difference between male and female children on the SDQ difficulties score (p=0.16). Also, the male and female children did not show a significant difference of the emotional symptoms subcategory score (p=0.40), the conduct problems subcategory score (p=0.43), the hyperactivity/inattention subcategory score (p=0.11), the peer relation problems (p=0.80), nor the prosocial behavior subcategory score (p=0.36).

Table 5

T-test of SDQ Subscales by Gender of Children

SDQ Subscale	Group 1: Male Children M(SD)	Group 2: Female Children M(SD)	*MD*	*t*	*p*
Emotional Symptoms	1.7 (1.86)	2.0 (1.63)	-0.28	-0.52	0.40
Conduct Problems	2.6 (1.92)	2.1 (1.47)	0.55	1.03	0.43
Hyperactivity/Inattention	4.1 (3.00)	4.4 (2.06)	-0.30	-0.37	0.11
Peer Relation Problems	1.6 (1.76)	1.2 (1.48)	0.39	0.78	0.80
Prosocial Behavior	8.0 (1.81)	8.2 (1.84)	-0.25	-0.45	0.36
SDQ Difficulties Scores	10.0 (6.60)	9.7 (4.18)	0.36	0.21	0.16

Table 6 shows some significant differences in the SDQ subset scores of White and Non-White children. Upon review of the two group means it is found that the average emotional symptoms subcategory score is significantly lower for white children (M=1.82) than for Non-White children (M=1.9). The difference between the means is 0.08 points on a 10-point subcategory scale. On average, White children also scored significantly lower on the hyperactivity/inattention subcategory (M=4.2) than Non-White children (M=4.3) for a mean difference of 0.1 point on a 10-point subcategory scale. However, White children on average

scored significantly higher on the peer relation problems subcategory (*M*=1.6) than Non-White children (*M*=0.9) for a difference of 0.7 between means on a 10-point subcategory scale. No significant differences were found between White and Non-White children in the conduct problems subcategory scores (*p*=0.53), the prosocial behavior subcategory scores (*p*=0.87), nor the SDQ difficulties score (*p*=0.20).

Table 6

T-test of SDQ Subscales by Race of Children

SDQ Subscale	Group 1: Non-white Children *M(SD)*	Group 2: White Children *M(SD)*	*MD*	*t*	*p*
Emotional Symptoms	1.9 (2.38)	1.82 (1.57)	0.08	0.12	0.02
Conduct Problems	2.0 (1.49)	2.5 (1.81)	-0.47	-0.75	0.53
Hyperactivity/Inattention	4.3 (3.50)	4.2 (2.36)	0.07	0.07	0.02
Peer Relation Problems	0.9 (0.99)	1.6 (1.76)	-0.69	-1.18	0.04
Prosocial Behavior	8.0 (2.06)	8.1 (1.76)	-0.09	-0.13	0.87
SDQ Difficulties Score	9.1 (6.33)	10.1 (5.48)	-1.02	-0.50	0.20

A statistically significant difference was found between the three age groups of children in the emotional symptoms subcategory scores (*p*=0.05) and the peer relation problems subcategory scores (*p*=0.04). Due to the large variance in sample size (Group 1, *n*=12; Group 2, *n*=26; Group 3, *n*=6) an LSD multiple comparison post hoc test was used to determine which groups were significantly different. The LSD post hoc test showed that Group 2 (*M*=1.1) and Group 3 (*M*=3.3) were significantly different in the emotional symptoms subcategory scores with a mean difference of 2.2 points on a 10-point subcategory scale. Adolescents (Group 3) showed

significantly greater emotional symptoms than toddlers (Group 1). Also using the LSD post hoc test, a significant difference between Group 1 (M=3.2) and Group 2 (M=1.0) in the peer relation subcategory scores was found with a mean difference of 2.2 points on a 10-point subcategory scale. Toddlers had significantly greater peer relation problems compared to children in middle childhood. There was no significant difference found between the groups in the conduct problems subcategory scores (p=0.12), the hyperactivity/inattention subcategory scores (p=0.31), the prosocial behavior subcategory scores (p=0.60), nor the SDQ difficulties scores (p=0.09).

Table 7

One-way Analysis of Variance of SDQ Subscale Score by Child Age Groups

SDQ Subscale	Group 1: Ages 2-3 *M(SD)*	Group 2: Ages 4-10 *M(SD)*	Group 3: Ages 11-17 *M(SD)*	*df*	*F*	*p*	Group Differences
Emotional Symptoms	2.4 (2.51)	1.1 (1.26)	3.3 (2.22)	26	3.48	0.05	2≠3
Conduct Problems	3.8 (2.86)	1.8 (1.47)	2.25 (1.71)	26	2.33	0.12	
Hyperactivity/Inattention	4.0 (3.00)	3.7 (2.70)	6.3 (3.78)	26	1.25	0.31	
Peer Relation Problems	3.2 (2.59)	1.0 (1.19)	1.3 (1.89)	26	3.73	0.04	1≠2
Prosocial Behavior	6.8 (2.86)	7.7 (1.78)	7.0 (1.83)	26	0.53	0.60	
SDQ Difficulties Score	13.4 (10.60)	7.6 (4.49)	13.0 (4.97)	26	2.62	0.09	

Qualitative Findings: Building recommended practices for working with domestic violence survivors who use opioids in residential services: A community engagement approach

After analyzing the seven focus groups three theme categories emerged: *Child Maltreatment, Action over Children,* and *Behavior Changes*. The sub-themes included in Child Maltreatment are Neglect, Physical Harm, and Mental/Emotional Harm. Neglect is defined as when a child's need are not met by a parent or other caregiver. Physical Harm is defined as experiences of actions that result in lasting physical wounds, or when a child is put in a situation where there is a greater chance of physical harm. Mental/Emotional Harm is defined as evidence that experiences children have, or actions taken against children have resulted in negative mental or emotional states. The next theme category is Actions over Children which includes the themes Parent Behaviors and Displaced Children. Parent Behaviors are defined as action taken by parents that directly or indirectly affect their children. Displaced Children are defined as children that are no longer in the same household as their parents. The third and final theme category, Behavioral Changes, only has one theme: Negative Behavioral Changes. This is defined as a change in a positive or neutral behavior to a destructive or upsetting behavior by a child. The codes that correlate with the themes are listed in the table below (See Table 8).

Table 8

Themes by Category, with Definitions and Codes

Theme Category	Sub-Theme	Theme Definition	Codes
Child Maltreatment	Neglect	When children's physical, educational, and emotional needs are not met by a parent or other caregiver.	Parentified Children Lack of Relationship with Parents Educational Neglect Lack of Parenting
	Physical Harm	Experiences/actions of harm resulting in lasting physical wounds or damage. Or actions that put children at risk in situations that may result in physical harm.	Child/ Youth Substance Use Human Trafficking Parental Substance Abuse While Pregnant. Child endangerment (drugs out, needles) Drug use worsening physical abuse
	Mental/Emotional Harm	Evidence that experiences/actions may result in mental or emotional harm to children.	Friendship with kids over parenting No boundaries with parents Digressing, bed wetting Witnessing Substance abuse Sad children Depression/Sadness

Theme Category	Sub-Theme	Theme Definition	Codes
			Mental Health
			Kids know their parents choose drugs over them
			Suffering
			Trauma
			Layers or Trauma
			Hard for kids to deal with
			Medicated Children
Action over Children	Parents Behaviors	Actions taken by parents that directly and/or indirectly affect their children.	Parents choose drugs over their children
			Parents lack proper judgment to parent
			No patience for their kids
			Lack of parental self-reliance
			Poor parenting
	Displaced Children	Children that do not live in the same household as their parent(s)	Kinship Care
			CPS Removal
			Fewer children in residential services
Behavioral Changes	Negative Behavioral Changes	When a child with positive or neutral behaviors turns to behaviors that negatively affect themselves and others.	Kids acting out
			Aggressive/angry children
			Children imitating parents' bad behaviors

Child Maltreatment

Child abuse and neglect are defined at the federal level by the Child Abuse Prevention and Treatment Act (CAPTA), "any recent act or failure to act on the part of a parent or caregiver that results in death, serious physical or emotional harm, sexual abuse, or exploitation, or an act or failure to act that presents an imminent risk of serious harm" (CAPTA Reauthorization Act of 2010). Child maltreatment as a broad term was not discussed in the focus groups, but under the CAPTA definition, neglect, physical harm, and emotional harm are important components of child abuse and neglect. And, these elements were frequently discussed by the focus groups in regard to the children of parents struggling with addiction.

Neglect

The most prevalent example of neglect throughout all of the focus groups was parentified children. Parentification of children occurs when a caregiver expects a child to complete tasks that are not reasonable to expect at that child's developmental age. This is considered neglect because children are left to themselves to do things that should be done by a caregiver. A group member in focus group three gave an example of a parentified child that had to take care of themselves:

> "They've become the parent of the household… they're the ones now having to get themselves up, and if they're lucky to fix a little sandwich and get themselves ready for school. And get to that school bus in time. And find clean clothes, cuz no one's done laundry for the week and no coat when they go out in the winter months."

These tasks may be age appropriate, however when the focus group member discussed this example, they used language to imply that it was too much for the child in question. In focus

group 7, focus group members gave examples of children that had to take care of themselves and their younger siblings. One person said:

> "The children feel like they got to take care of their mom…and the other siblings… I have somebody the other day who was like, well, she knows how to give their siblings all these medication and her mom was like, she can manage that. I was like, she's twelve, she shouldn't be managing that."

While in a focus group 6, members described a complete role reversal of parent and child, where the child made sure that the parent was doing what they were supposed to do, a focus group member stating:

> "The parent-child dynamic shifts so child is now the parent caring for the mom. Mom, did you eat, mom did you do your chore, mom ,did you go to this meeting? … it becomes the child has to be the one to make sure that mom keep the house in shape."

Another common code in the theme of neglect was a lack of parenting. Focus group members had seen children completely ignored by their parent or a parent was unable to meet the needs of the child because of the effect of the substances they were using. A member of focus group 1 said, ""I see an increase in neglectful behavior because the mom is under the influence so they're not able to properly care for their children." Further exemplifying one mother's inability to care for her children, a member of group two said:

> "We had a mom recently… She had six-year-old twins. And it just kind of deteriorated to where she really was not able to care for them. I mean, they'd be like hopping up and down, or in bed asking for breakfast, and she's just completely out."

The parent's inability to meet the child's needs includes the need to have a stable relationship with a caregiver. This lack of relationship was discussed as one group member said, "They just

don't get the parenting that they need. They get a lot of neglect. They get a lot of indifference. Lots of neglect… They're so starved for attention."

Physical Harm

Physical harm to a child can occur from incidents that predate their birth. One focus group member discussed how drug use during pregnancy negatively affected the health outcomes of some children in the shelter's care, stating:

> "I've worked with a couple young moms… both of [their children were in] preschool… They [the children] had developmental delays and both moms admit they use heroine during their pregnancies."

Groups one and three discussed how children were trafficked by their caregivers in order to pay for drugs and possibly other necessities. A participant in group one explained, "[I] also see parents, mothers, trafficking children out for drugs, or rent, or whatever it may be to keep a roof over their head, to keep their drugs coming." When trafficked, a child can be exposed to physical, sexual, mental, and emotional abuse. And this is happening more and more as a participant member in group one stated, "We've had a lot of issues where mom is addicted, and she will kind of turn a blind eye and let her dealer have his way with her children… in exchange for drug use."

Other focus group members discussed how children were put in danger because parents left drugs and drug paraphernalia in the reach of children, saying, "Now what's dangerous is kids are gonna get into people's needles that are laying [out]. You know some of the heavy stuff…" This allowed the children to be exposed to drugs at a young age, while some became addicted. A participant in group four shared this experience:

> "He said, you know I smoked marijuana for the first time when I was 8 years old. This is a 16-year-old boy. He said, my mom would leave her bottle of pills laying around. I took the stuff just to see if I could get high."

Another example of youth substance abuse was shared when a participant in group one said, "They become addicted to drugs younger and younger because their parents use... I had the girl whose mom shot her up at 14…" It was only mentioned once that physical abuse, such as beatings, worsened with drug use when a focus group participant said, "… with abuse, used to be smacking around, now they use guns. Used to just be can't have them bigger… than a thumb… Now they beat them with anything they can get their hands on, so the drugs have gotten worse…"

Mental/Emotional Harm

Themes of mental and emotional harm were defined by more codes than any other theme. This was partially due to the fact that mental and emotional harm is expressed in many ways and also because each group gave many examples about how the saw the children in the shelter showing signs of mental or emotional harm. One focus group member mentioned that children are digressing more, including wetting the bed, stating, "… a lot more children wetting the bed more, digressing more."

Groups five and six spoke directly about the trauma specifically. A focus group member in group five was so aware of the trauma that the children of their clients experienced that they gave them a learning packet about trauma as they explained to the group:

> "… what I've started to do is I make like a parenting package, it's a general thing about trauma and how trauma affects children at different ages and what that looks like for each

child. I did that and then I put an additional section here about additional section here about addiction…"

Another member of group five added insight about how the parents themselves have experienced trauma when they said, "… when we're traumatized, we tend to only focus our trauma, we don't necessarily focus on our kid's trauma. So, we're retraumatizing them every time we breathe…" Group six discussed how children experience a form of secondhand trauma from their parents and trauma from witnessing their parent's substance abuse:

> "From my limited experience working with the people that we've worked with during recovery, the children in shelter have trauma just like the adults. But the children of the people who are in recovery or actively using having a lot more potential for trauma. Worrying about mom… they have to come back and check on mom or leave the room to go find mom and make sure that she's okay before they can relax…"

On the other hand a group member remarked how witnessing parental substance abuse from a young age, a child may see substance use as normal and expected- eventually leading the child to seek out substances themselves explaining:

> "So they're just sitting there watching their parents who are the only thing they want is that fix, that drug. The need that. So the kids are sitting back watching, and that's what's important to their parents. And as bad as they feel about it and as hard as it hurts them when they become older. That's what they know and that's what they're gonna seek out."

Multiple groups discussed how parents did not have any boundaries with their children, shown in the way parents communicate and the expectations they put on the parent-child relationship. This lack of boundaries allows children to know and witness things before they are developmentally ready. As a participant in group one explained:

> "… some parents… view their children as friends. My close friend, and I'm going to share with you. You're gonna be my sole support, and they relinquish their parenting role to have the child become their friend."

And almost every group discussed how children appeared to be sad, depressed, or suffering because of their parent's substance use. A person in group one best expressed the suffering they see when they said, "It's just very common to see the sadness in the children that just kind of permeates their existence. You don't even really see much happy play at all… you don't see [those] joyful, carefree kids."

Two focus groups also said that this sadness was in part due to the child's knowledge that their parent had chosen drugs over them. As a participant in group three stated, "Kids know that mom has chosen the drugs over them… we used to worry about mom choosing the abuser over them… which is still a thing, but now mom's choosing drugs over [them]."

Action Over Children

Parent Behaviors

Multiple groups talked about how parents did not have parental judgement, or parental intuition to help them make decisions about their children. A participant in group one shared this experience:

> "We had a mom that… took the crib mattress off the baby's bed and she was gonna ride it down our stairs from our second floor… When our advocate tried to stop her, she [the mom] said, this would be funny… So their judgement is just not there."

This could lead to the parent not caring for the child at all.

One focus group member spoke about parent's lack of patience for their children when they make age appropriate mistakes, saying, "… they may use some very profound, colorful

language with their child and when the child repeats it back, they don't have the tolerance for that child to do [that]."

Another focus group member said:

> "We had a mom that would let her 16-year-old son smoke marijuana in the bedroom because it calmed him down… she goes, well it's the only thing he can do to keep him calm, and if that's what is takes."

The group member further explained that when the agency approached to mother with services for her son, she refused them. While poor parenting is a subjective code at best, it may describe a parent that would rather their child smoke marijuana than go to therapy.

Displaced Children

Every focus group discussed how children were in alternate forms of care. There was an immediate notice by service providers that there are fewer children in the shelters. In group five when asked about children in the shelter one participant said, "That's the forgotten population." To which another person further explained, "They're not there." Another participant in focus group one remarked:

> "We have a lot of kids that aren't in shelter with their moms anymore, as years ago they might have bee. We've had a lot of women come lately without their children because they have been removed."

They believe this lack of children is because more children have been removed from their parents by child protective services (CPS). This has resulted in greater cooperation of shelters with children's services as one participant said, "There's a lot of working with children services cuz we'll have our women come in and they have open cases."

When removed, children are either placed in a foster home or kinship care. Kinship care is when the child is placed with a family member or close friend rather than a stranger. This is preferred because it is less restrictive to the child. That being said, a group member in group two also explained that rather than seeing the natural fathers bringing children to visitation at the shelter they have seen more grandparents caring for their daughter's children, saying, "[In] the supervised visitation center… we went from having men being the abusers and the non-custodial parents, to now it's just young mom's struggling with addiction. So, the grandparents have the kids more." This sentiment of increased kinship care was echoed in group six when a participant said, "… right now, easily 90% of the visitations are, again, grandparents who are caring or have custody for grandchildren. And then bringing them to visit natural mother or father because of a substance abuse issue."

Negative Behavioral Changes

Two groups spoke specifically about how children in their shelters are changing and take on negative behaviors. These behaviors include shoplifting, verbal and physical aggression towards others, and substance use. A participant in group four stated, "… a lot of them [are] shoplifting… They're so starved for attention." A different participant in group three talked about an aggressive child when they shared, "For example, we have one right now, she's four… And she, the little girl calls her mom stupid, She hits her. She kicks her. She screams at her." Multiple focus group members discussed how they felt these behaviors showed that the children are following in their parents' footsteps. In group four a group member said:

> "… I got 13,14-year-old boys in there that are addicts already. They're already going through the juvenile system because they can't stop the drugs. Why? Because my mom and dad, they did drugs all my life, since I was a kid, since I was born."

And, in group three a participant was so concerned about children taking up substance use after their parents, the participant said, “We need to look at our kids, what’s happening there, so hopefully their behavior s don’t accelerate or they don’t follow in mom or dad’s footsteps.”

Discussion

Summary of Results

Ohio START Survey

The results of the SDQ from the Ohio START show that the overall average of the scores of all age groups is well within the normal range of scores. Upon a further investigation it can be found that some individual age group do have scores that are borderline. Adolescents (Group 3) have an average borderline score for the hyperactivity/inattention subcategory. This finding is supported by previous research that has found higher rates of substance use among parents of youth with an attention deficit disorder or a conduct disorder (Chronis et al., 2003; Lang et al., 1999). However, because the toddler (Group 1) and middle childhood (Group 2) did not show heighted levels of hyperactive behaviors no correlation of parental substance abuse and a child’s hyperactivity/inattention sub-score on the SDQ can be made.

When compared to the other groups the findings of significant differences are as follows: adolescents showed significantly greater emotional symptoms than toddlers and toddlers had significantly greater peer relation problems compared to children in middle childhood. Adolescents may show greater emotional symptoms than toddlers because they are more knowledgeable about substance abuse and are therefore more troubled by their parent’s addiction (Smith et al., 2016; Duggan et al., 1991).

Children of parents that abuse substances are at a four times greater risk to experience neglect (Smith et al., 2016). Neglect, especially before a child is school age is extremely

detrimental to their mental health (Hildyard & Wolfe, 2002). This may account for the significant difference between toddler and middle childhood children in their peer relation problem sub-score. If a toddler has experienced neglect it is more likely that their parent will not go out of their way to help them socialize with other toddlers, while children in middle childhood are school age and are forced to interact with other children.

While the scores were all within the average range when comparing White and Non-White children it is important to note that White children scored significantly lower in the emotional problems and hyperactivity/inattention subcategories when compared to Non-White children. Conversely, Non-White Children scored significantly lower in the peer relation problems subcategory. When analyzing applicable literature, nothing was found to support nor dispute these findings, there is a great need to further research the differences between the effects of parental substance abuse on children of different races.

Building recommended practices for working with domestic violence survivors who use opioids in residential services: A community engagement approach

The most pervasive finding was providers experience with parentified children. Every group had something to say about children in charge of more than they should at their developmental age whether it be for themselves, their siblings, or their parents. While it is important for children to learn life skills, research shows that if a child is forced into a situation where they develop parental qualities, their development in other areas of their life may be compromised (Barnett & Parker, 1998; Bekir et al., 1993). The parentification of children stemmed from the initial neglect the parents gave when they used opiates. Multiple focus group participants noted that because of their drug use, parents were “tired” and unable to perform basic care giving tasks. In the absence of that help, children step up to meet their basic needs.

This finding was echoed in the recent study by Tedgård et al. as the author discussed that the children they interviewed shared a similar experience of taking on parental duties because of their parents substance abuse (2018).

A parent's opiate use often lead to children being removed from their care completely. ODVN providers are not interacting with children as much as they used to because they have already been removed by CPS. The focus group members reflected that they were getting more women in their shelter because they are following a case plan than ever before. Their reflection is consistent with the national rise in youth in foster care of ten percent from 2012 to 2016 evaluated in the 2018, Office of the Assistant Secretary for Planning and Evaluation (ASPE) research brief (Radel et al.). This national study also found that parental opioid use was directly correlated to more children entering into foster care (Radel et al., 2018). In another study it was found that 32.7% of women in opioid use disorder treatment had their children removed by CPS (Taplin & Mattick, 2014). The focus groups also highlighted that the children that were removed are placed with grandparents or other kind rather than foster parents. This is a contrast to the ASPE research brief which found that due to generational substance abuse it was more difficult for CPS workers to find kinship placements (Radel et al., 2018). Focus group members may have noticed more kindship caregivers because they are not accustomed to so many clients having children in the custody of CPS, also the ASPE brief recommended a push for kinship care and service providers may be witnessing a successful shift in out of home care. Kinship care is a positive move forward because when children are placed with family members it is usually less restrictive than foster care. Studies have shown that when children are in kinship care instead of foster care they are successfully reunited faster, they are less likely to develop behavioral

disorders, less likely to experience institutional abuse, and have an overall better level of well-being (Rubin et al., 2008; Winokur et al., 2008).

Most of the reports of physical abuse was indirect to children by the parents. One of the most haunting findings was that of intrafamilial human trafficking. Intrafamilial human trafficking occurs when one family member sells another family member, often for drugs, but it can be for anything from a carton of eggs to money off of rent. One focus group member did not say that the mother had trafficked her children, rather that the mother "turned a blind eye" to allow her dealers to "have their way" with her children. This is human trafficking, and while the mother may not be directly hitting on or yelling at her children, this situation is arguably worse because the child can endure so many abuses at the hand of someone else and their caregiver would have no idea. Years of research have shown that sexual abuse has a myriad of negative effects including, but not limited to, sexually transmitted infections and mental disorders (Felitti & Anda, 2010; Neumann et al., 1996; Selvius et al., 2018). Although only two focus group members mentioned trafficking children, this may be because the idea of intrafamilial trafficking is not always well taught nor always considered when people think of physical abuse so mandated reporters do not know that what they have witnessed or heard should be reported. This is especially important to consider as children with parents that abuse substances are three times more likely to suffer sexual abuse (Smith et al., 2016).

Another overwhelming finding were the reports of children that were sad or depressed. Like children of a person who is an alcoholic, children who have a parent that abuses opioids may be distressed by their parent's illness (Duggan et al., 1991). This sadness may also be tied to the loss of childhood that many children of parental substance abuse experience. When a child is preoccupied with parental tasks, they are not able to enjoy being a child (Barnett & Parker,

1998). Depression can also be a result of neglect of children at all ages, (Hildyard & Wolfe, 2002). The culmination of effects of parental opioid abuse causes mental and emotional disruption for children.

Limitations

Original Studies

Ohio START Survey. Participants in this study are limited to families who have been involved with the pubic child welfare agencies in the rural regions of Southern Ohio and participated in the Ohio START program due to their substance use and child maltreatment. Therefore, study results may not be generalized to other populations (e.g., individuals who are not in the child welfare system) or other geographic areas.

There is also potential for attrition because the participants are vulnerable populations (opiate affected, child welfare-involved) who may lack motivation to participate in a research study. Also, there may be some other threats to internal validity such as history and maturation. For example, changes in the study outcomes (e.g., parenting behaviors, child behavioral problems) may be due to some other events occurring concurrently with the Ohio START intervention or some naturally occurring changes over time (e.g., child exhibiting less externalizing behaviors a s they get older) that could be confused with an intervention effect.

Building recommended practices for working with domestic violence survivors who use opioids in residential services: A community engagement approach. Participants in these focus groups are limited to ODVN service providers. Their responses, while genuine, are limited to their scope of practice and first-hand experience of the opioid epidemic in the clients they have worked with. This study may not be generalizable to the general population as the

population that is being discussed is strictly limited to the children of domestic violence survivors, in the care of ODVN.

Secondary Analysis

As a secondary analysis, this study was limited to the information that was already available. The two original studies did not have the same research aim and because of that they are not directly comparable as they would be in a traditional mixed methods study. There is no opportunity to follow up with participants from either of the original studies for follow up questions. Also, because this study did not oversee all of the original data collection there are possible unknown biases that cannot be accounted for. One of which may be that many parents completing the Ohio START survey did not have their children in their care currently so they may not have been able to answer the SDQ accurately.

Conclusions

The parents that responded to the SDQ about their children viewed their children in a much more positive light than the service providers. While the SDQ scores were on average in a normal range, the information from the ODVN providers was that children are experiencing heightened neglect, abuse, and emotional distress. However, due to the differences in the research aims of the original studies it is not possible to make a clear comparison between the two results.

Implications and Future Research Recommendations

The qualitative results of this study fall line with the experiences of others recording the experiences of children that have parents that abuse opioids and other substances. In the future, a mixed methods study that has direct study aims about how opioid use affects children in the views of both their parents and service providers should be done. This could be done through the

Ohio START infrastructure with both parents and providers answer an SDQ about their children and other long form qualitative results. The evidence of human trafficking also calls for more research about the risk that children whose parents abuse opioids are to be trafficked. As more children enter kinship care, it is also important to research how they act in the care of their relatives and how that compares to those in the care of strangers.

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