Substance Use and Parenting

Best Practices for Family Court Practitioners

EDITED BY STEPHANIE TABASHNECK, PSY.D., ESQ.

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Regards,

Stephanie Tabashneck, Psy.D., Esq.
Editor

Introduction

Stephanie Tabashneck, Psy.D., Esq. Private Practice, Wellesley, MA

Every day, families and communities across the country are impacted by substance misuse. A parent's drug use can destabilize the family unit, wreak havoc on the parent's ability to care for their child, and lead children to feel unsafe at home. Some of these families end up in family court. Due to the complexity of these cases, it is often unclear to family court practitioners how best to proceed.

The first objective of this guidebook is to infuse science and evidence-based practices into family court decision making with the goal of better serving children and parents impacted by addiction. This guidebook will help answer some of the questions that family court practitioners grapple with: When is it safe for a parent in recovery from a substance use disorder to transition from supervised visits to unsupervised visits? Under what conditions is drug testing indicated? What should happen if a parent has a recurrence (relapse)? How do we protect children when their parent has a substance use problem?

A second objective of the guidebook is to encourage the reader to apply nuanced decision-making when approaching a family court case with substance use dynamics. While it would certainly make things easier if there were a one-size-fits all approach to use when charting a course of action in these complex cases, instead what is required is an individualized response. This response is derived from an understanding of the needs, strengths, and values of the parent with a substance use disorder, the nature of the parent's substance use, the state of their mental health, the developmental stage and needs of the child, and the supports and supervision mechanisms available.

Last, it is important to recognize that most people struggling with addiction can and do get better. Indeed, some of the best parents I know are in recovery. They value the time that they have with their children, feel exceptionally guilty about their past behavior, and have dedicated their lives to making up for the mistakes they made when in the throes of their addiction. This book is dedicated to them.

Prologue

Beth Starck, Recovery Coach

I was diagnosed with bipolar II disorder several years ago at a top hospital in Boston.

While I was a patient at this hospital, I was lucky enough to meet a doctor who finally found the key to unlock the mystery of my brain. I had an answer to the questions I had been asking myself my entire life. The racing thoughts, pressured energy, negative voice in my head, and bouts of depression. Finally, I had an answer.

My bipolar II diagnosis, however, was neither where my story started nor ended. I was originally brought to the hospital due to hypothermia. I was found nearly unconscious after dipping my toes in the waters of a suicide attempt, both literally and figuratively. It is more than worth mentioning that besides having bipolar disorder, I also struggle with alcoholism. All I could remember about that cold April day was driving to the river, drinking a pint of vodka, leaving my car running, placing my wallet on a bench, taking my shoes off, and getting in the water. After wading through the river, fully clothed, almost completely submerged, a kayaker saw me and asked if I needed help. Completely disoriented and likely quite delusional, I said "No, my dad's coming to get me." Luckily, the stranger could sense that something was amiss. She brought me to shore and called 911. It was not until days later that I realized she had saved my life.

Before I got into the river, my life had been on a rapid downward spiral. I had been served divorce papers, had my custody of my son compromised, and was in the midst of erratic drinking that had become God-awful after he was born. But truthfully, my drinking and my mental health had always been awful. I was never a "good" drinker. After my son was born, it felt like the train had left the station, never to return. It felt as though I had no control over what I was doing or who I was becoming.

In addition to alcoholism, I was always battling this other "thing," but I never knew what it was. I would be diagnosed as suffering from depression or anxiety disorder. I would be given all these medications, but nothing ever worked. The "thing" was always still there.

After I received a proper diagnosis, I got out of the hospital and used bipolar II as a crutch to continue my drinking. I would tell people, "Don't worry, I am not an alcoholic, I am just bipolar." At that time, I thought the label of "bipolar" would hide the alcohol problem I was not willing to admit to myself. But it did not. It took me many years to process the feelings and emotions around my drinking.

I have experienced a lot through my battle with addiction and bipolar disorder, but there is one event in particular that made an everlasting impression on me.

After my maternity leave, I went back to work at a daycare center in Waltham, Massachusetts. Right outside the daycare window was a pond, and in the spring, we would watch families of geese give birth to goslings. They would create these little families and we would see them go about and grow up together. The children at the daycare absolutely loved it. During this time, I

was in the midst of my custody issues. I had lost everything at this point: my son, my marriage, my home. My time with my son was supervised, and I was not allowed to drive in a car with him. I was crippled by embarrassment and shame.

One day while I was leaving work, I saw a goose all by herself, limping and struggling to walk. When I say that the goose was a female, it is because I knew she was the mom. She was alone, and she didn't know where her family was. The area was not that big. The gaggle of geese were always able to find each other. But when I saw her, I knew she was the mom, and I knew she was lost. I immediately pulled over and started crying the tears I had been holding in for so long. It was the most cathartic experience to identify with this goose. These were the feelings that I had stuffed down and hidden. I never wanted to tell anyone the shame, the guilt, the fear, and the awfulness that comes from having your child taken away from you. I called the building maintenance daily, driving them crazy, saying, "You have to go help the mother goose. She is lost and scared and cannot find her family and she is alone. She wants to go home." Seeing the mother goose all alone was an awful reminder that mothers should not be apart from their family; they should not have to miss their babies. But it happens, and when it does, it is inexplicably hard.

I find there to be a particular type of shame for moms with recovery issues and mental illness. From the time we are young women, we are told that we can do this amazing thing with our bodies and become mothers. We will meet someone, start a family, and maybe spend weeks on vacation on the Cape. It was not like that for me. After I gave birth, I had slowly started to lose my mind.

"Meeting" the goose impacted my life so strongly that I went to Alcoholics Anonymous meetings and talked about her, and even shared my concerns about her at home. Everybody would ask me about the mother goose, and I would tell them she was still lost. When she was finally reunited with her family, I rejoiced. I took it as a sign that I would reunite with my son one day, too. She had given me hope.

Shortly after my interaction with the goose, I remember reading an article about a mom who lit herself on fire on a playground after the state had taken her child away from her. She had a complicated type of bipolar disorder that kept getting misdiagnosed. I understood why she acted in the way that she did. I could relate to those feelings. I do not want to say that I ever thought about lighting myself on fire, but I thought numerous times that I was not strong enough and if I could not fight back, I might as well give up.

Six months after my marriage ended, I went to rehab for my problems with alcohol. Upon being released, I was sober for six months before I relapsed. The fight to prove that I was stable and capable was much more difficult during round two. It involved a lot more boxes to check and hurdles to jump over. My ex-husband and I worked with a parenting coordinator, and I used a portable breathalyzer. I sent an active and full calendar of the AA meetings I attended, as well as my weekly doctor's appointments, to the parent coordinator. While it was so hard, I wanted nothing more in my life than to do everything asked of me and to do it well.

In May 2018, I regained shared legal custody of my son, and in January 2019, I was granted 50-50 physical custody.

Over the years, I have heard judgments made about my behaviors and actions I have taken. I understand it. I can see how someone may not know what it is like in to be in my shoes. But I

want to share what I have taken from this experience. I want to share my struggles with shame and embarrassment. I want to share that being mentally ill and struggling with alcoholism is not something to be looked down upon. It simply means that my brain works differently than others'. During the time I have been working to regain my life, I have been called a litany of colorful names and falsely accused of numerous things. These are things that I wish had never happened. The worst name that I was called at the time—which brought me to my knees in tears—was mentally-ill Mom. But I am a mentally-ill Mom, and I am an alcoholic. These are facts, and that is okay. But there are more facts about me that are equally important,. I am a good person and a fantastic mom, and I love my son more than anything on this planet. I now have the tools, the resources, the strength, and the courage to handle motherhood one day at a time.

My son is the most amazing, empathic, compassionate, and forgiving child on this planet. He has seen things that I wish to God I could take back, but I simply cannot. My psychiatrist tells me that he will not remember anything from birth to age three, like a form of baby amnesia. My son's life will be a little bit different because I find having bipolar to be tricky sometimes. Things can seem loud, I need to focus to really understand what people are saying, and I overanalyze many of the decisions I make. But I study it, I learn about it, and I talk about it. I go to therapy once a week. I see my psychiatrist bi-weekly, and I work with a sober coach. I always want to be ahead of this disease, because on the one day I am not ahead, there is no telling what could happen. I continuously remind myself that I am only here because of lucky circumstances, and that wonderful woman kayaking on a cold April day.

I have taken my experience and decided to make it my life's passion to share my story so that maybe someone in a similar situation will not feel so alone. It is my job to share that life can be amazing, and there is a light at the end of the tunnel. It can be an emotional fight to stand up to negative self-talk and to hear what people say about you. It can be difficult to move past the shame and embarrassment. But it is the most rewarding experience.

Whenever I speak about my experiences, I like to put my hand on my heart. I have a small tattoo of a heart on my hand that syncs up with my heart. In an AA meeting, I once heard that putting your hand on your heart allows the person you are speaking with to realize that you mean the words you are saying. I like to put it there today when I share my fears, my insecurities, my hopes, and my dreams.

Life is so different now. I never held my head up high before, but I am confident in the decisions I make today. I finished college. I'm in a master's degree program for social work. I won a large scholarship for my academic achievements and for the grit and tenacity it has taken me to get here. I am a peer mentor and I talk…a lot. I juggle two jobs, school, and motherhood; being a mom is the most important job in my life. I can say with certainty that I am proud of who I am and how far I have come.

If I can do one thing well in my life, besides being a good mom, I want to help others not feel as alone as I did. I did not have anyone to identify with during the most challenging years of my life. I did not have any friends who had lost custody of their children. It was so heartbreaking to open up to friends and family, to tell them "I don't have custody of my son." The time apart is something I still struggle with today.

Today, I am full of gratitude. Of course, there are moments that I cannot find gratitude; I am still human. But, in the big picture, I thank my lucky stars all the time. Several years ago, if things

had been different, I would not be alive to write this story. It isn't even a story; it is the true tale of how I changed my life and began to recover. So many amazing people helped me and offered me the opportunity to recover and seek help. It took support from my lawyers, my parenting coordinator, my ex-husband, our families, my friends, recovery programs, and my son. It took me seeing that I was not a waste of life or damaged. I was a person that needed help and guidance. I was sick. Really, really sick. I could change and thrive and live an amazing life sober. Sober. What a gift it is.

Not a day goes by that I do not remember my past. Remembering is acknowledging where I have been and what I have done. Remembering is staying on the path that has been gifted to me. Remembering is helping people like myself. Remembering is not living in guilt and shame but reminding myself how different my son's life would be and how I would have altered the trajectory of so many people's lives, especially my son's, if I had killed myself, stayed on the path I was on, or given up.

Today, things are good. I am four years sober. I am working on a master's degree in social work. I put one foot in front of the other every single day. My son is so happy, his father is happy, and I am happy. Our lives are going in two different directions, but we co-parent well and always do what is best for our son.

Every morning I promise my son that I will try, I will stay strong, and I will be brave. I hope by sharing this, I am showing you bravery. If anyone reading this needs it, I hope I am offering to you your own hope, because without hope and a belief that change is possible, there is nothing.

RESOURCES

Alcoholics Anonymous: www.aa.org

Depression and Bipolar Support Alliance: www.dbsalliance.org

HeretoHelp: www.heretohelp.bc.ca

National Suicide Hotline: www.suicidepreventionlifeline.org, 1-800-273-8255

SMART Recovery: www.smartrecovery.org

Chapter 1: Definitions

Stephanie Tabashneck, Psy.D., Esq. Private Practice, Wellesley, MA

I. What is addiction?

Addiction is a chronic, relapsing, brain-based disease characterized by continued use of a substance despite significant harmful consequences. When an individual becomes addicted to a substance, significant changes occur in their brain. Addiction disrupts the brain's reward system and produces powerful cravings.[1] The pleasure from drugs or alcohol is experienced as more satisfying than other experiences typically perceived as pleasurable, such as relationships, food, and sex. Significant dysfunction occurs in psychological, social, and biological functioning. This is often most noticeable in the continued use of drugs and alcohol even when use leads to major life problems.[2] Like other chronic diseases such as heart disease and diabetes, addiction generally involves a series of relapses followed by remission. Improper treatment, stress, and unmanaged co-occurring conditions (e.g., mental illness, medical problems) can increase risk of a recurrence. In fact, individuals with substance use disorders are at risk of relapse even after many years of recovery.

II. What is a substance use disorder?

The criteria for substance use disorders are set forth in the Diagnostic and Statistical Manual, Fifth Edition (DSM-V). The DSM-V includes diagnostic criteria for substance-related disorders for ten classes of drugs: alcohol, caffeine, cannabis, phencyclidine, hallucinogens, inhalants, opioids, sedatives/hypnotics/anxiolytics, stimulants, tobacco, and other.[3] The central aspect of a substance use disorder is continued use of the substance despite significant life consequences. Symptoms which may or may not be present include using larger amounts of the substance over time, failing at efforts to stop or control use, excessive amounts of time dedicated to obtaining, using, or recovering from the substance, strong urges to use, use resulting in failure to accomplish major life obligations at work, school, or home, continued use despite interpersonal problems, reducing or stopping important activities due to substance use, a need for larger amounts of substances over time or diminished effect of the substance, and withdrawal.

An individual may have a mild substance use disorder if two to three of the symptoms listed above are present, a moderate substance use disorder if four to five of the above symptoms are present, and a severe substance use disorder if six or more of the above symptoms are present.

Early remission is generally accomplished if the diagnostic criteria has not been satisfied for between three months and 12 months but the full criteria for the disorder was initially met. Sustained remission is generally accomplished if the full criteria has not been met for 12 months.

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1 *Definition of Addiction*, Am. Soc'y of Addiction Medicine (Sept. 15, 2019), https://www.asam.org/resources/definition-of-addiction.
2 *Id.*
3 American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders (5th Ed. 2013).

RESOURCES

American Society of Addiction Medicine: www.asam.org

Substance Abuse and Mental Health Services Administration: www.samhsa.gov

American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders (5th Ed. 2013)

Chapter 2: Parental Substance Use Disorder and Child Development

Stephanie Tabashneck, Psy.D., Esq. Private Practice, Wellesley, MA

I. Introduction

One in eight children live in a home with a parent who has a substance use disorder (SUD).[4] Most of these children are under the age of five.[5] Studies estimate that as many as 80% of child maltreatment cases involve a parent with substance misuse.[6] Parent SUD impacts children in a myriad of ways depending on the nature and severity of the substance use, as well as the child's development, age, special needs, external social supports, and level of resilience.

Often children of SUD parents have basic needs that go unmet. These children are also at heightened risk of trauma. Notably, children with parents who misuse drugs or alcohol are three times more likely to be the victim of physical, sexual, or emotional abuse and four times more likely to be neglected.[7] These children are often sad, lonely, and emotionally and socially withdrawn with low self-esteem. Further, children of parents with a SUD are more likely to experience other collateral consequences, including educational delays, mental health problems, behavioral problems, and poor medical and dental care. Negative outcomes for children are even more pronounced if a parent has a co-occurring psychiatric issue or if both parents have a SUD.

II. Genetic and Environmental Factors

Genetic Influence

Children whose parents have a substance use disorder are much more likely to have a substance use disorder later in life. Specifically, as compared to their peers, children who have a parent with a SUD are more than twice as likely to develop a SUD by young adulthood, and as many

4 Rachel N. Lipari & Struther L. Van Horn, The CBHS Report: Children Living with Parents Who Have a Substance Use Disorder (August 24, 2017), https://www.samhsa.gov/data/sites/default/files/report_3223/ShortReport-3223.pdf.
5 *Id.*
6 Nancy K. Young, Sidney L. Gardner & Kimberly Dennis, Responding to Alcohol and Other Drug Problems: Weaving Together Practice and Policy 105 (1998).
7 Vincent C. Smith, Celeste R. Wilson & Committee on Substance Use and Prevention, Families Affected by Parental Substance Use, 138(2) Am. Acad. Pediatrics (2016).

as half of these children will develop a SUD by the time they turn 18.[8] This is in part influenced by genetics, which play a significant role in personality, temperament, mental health, physical health, and vulnerability to risk factors associated with substance use disorders.[9] Family and twin studies indicate that the genetic heritability of Substance Use Disorders involving alcohol, cannabis, cocaine, and other illicit drugs is between 30% and 70%.[10] Genetics have been found to influence initiation of use of addictive substances, subsequent misuse of the substances, addiction, and relapse.[11] This is due, in part, to the role genetics plays in risk and novelty seeking, stress reactivity, and impulsivity. Genetics also influence the extent to which an individual experiences pleasure after using an addictive substance.

Environmental

Children are also influenced by environmental factors, including parenting deficits triggered by SUD, decreased parental warmth, diminished responsiveness to children's needs and cues, harsh parenting, chaotic living environment, lack of routine, neglect, and physical abuse. Further, parents may model drug use behavior in front of the child, which also can increase a child's risk of developing a substance use disorder. Stimulants can lead parents to become aggressive, impulsive, and hostile.[12] Some drugs, such as methamphetamines, lead to severe mood swings which can be frightening for a child. On the other hand, parents who use sedating substances, such as alcohol and heroin, are more likely to be non-responsive, inattentive, and withdrawn. Parents with an opioid use disorder are at heightened risk of diminished caregiving skills, including neglect and abuse.[13] A research review by Virginia Peisch et al. identified several studies that have found significant differences in parents with opioid dependence in sensitivity to their child's needs, warmth, and level of involvement.[14] Parents with opioid use disorders were found to be more likely to evidence harsh parenting styles and use non-preferred tactics such as humiliation.[15] Overall, parents with a substance use disorder tend to engage in fewer positive parenting behaviors and display more negative parenting behaviors. When present when a child is younger, including under the age of five, all of these factors can impact parent-child attachment.

Along with caregiving deficits, parent SUD has a profound impact on a child's day-to-day world. Homelessness, housing problems, job loss, financial instability, food insecurity, marital problems, removal, and incarceration are common consequences of addiction. Additionally, children of SUD parents may be exposed to unsafe persons leading to sexual abuse, sexual exploitation, and other trauma [Note: For a further analysis of this topic, please see Chapter 8: Substance Use and Commercial Sexual Exploitation in Family Court].

8 Laurie Chassin, Steven C. Pitts & Christian DeLucia, *The Relation of Adolescent Substance Use to Young Adult Autonomy, Positive Activity Involvement, and Perceived Competence*, 11(4) Developmental Psychopathy 915-32 (1999).

9 Antonio Verdejo-Garcia, Andrew J. Lawrence & Luke Clark, *Impulsivity as a Vulnerability Marker for Substance-Use Disorders: Review of Findings from High-Risk Research, Problem Gamblers and Genetic Association Studies*, 32(4) Neuroscience & Biobehavioral Rev. 777-810 (2008).

10 Arpana Agrawal & Michael T. Lynskey, *Are There Genetic Influences on Addiction: Evidence from Family, Adoption and Twin Studies*, 103(7) Addiction 1069-81 (2008).

11 Mary Jeanne Kreek, David A. Nielsen, Eduardo R. Butelman & K. Steven Laforge, *Genetic Influences on Impulsivity, Risk Taking, Stress Responsivity and Vulnerability to Drug Abuse and Addiction*, 8(11) Nature Neuro 1450 (2005).

12 Ikechuwu Ukeje, Margaret Bendersky & Michael Lewis, *Mother–Infant Interaction as 12 Months in Prenatally Cocaine-Exposed Children*, 27(2) Am. J. Drug Alcohol Abuse 203 (2001).

13 Virginia Peisch et al., *Parental Opioid Abuse: A Review of Child Outcomes, Parenting, and Parenting Interventions*, 27(7) J. Child & Fam. Stud. 2082 (2018), https://link.springer.com/article/10.1007/s10826-018-1061-0.

14 *Id.*

15 *Id.*

III. Child Development and the Impact of Parent SUD

Secure attachment – the strong bond between an infant and a caregiver – is a critical developmental objective in early childhood.[16] The nature of a child's attachment to a caregiver profoundly affects the child's long-term emotional and psychological wellbeing, including their ability to regulate emotions, their physical health, and their way of relating to the world.[17] Heavily influenced by parental behavior, the groundwork for secure attachment is established in the first several years of life within the context of parent responsiveness, closeness, and attunement to the infant's needs.[18] Notably, parents with an SUD are likely to be preoccupied with tasks unrelated to caregiving responsibilities, such as obtaining and using drugs, recovering from the temporary effects of drug use, and avoiding withdrawal symptoms. As a result, parents with SUD are more likely to be inattentive to their child's needs and miss their infant's cues. This lack of attunement leads to a child's emotional deprivation and impedes the development of secure attachment. Children with insecure attachment are at risk of mental health problems, including anxiety, depression, attention deficit hyperactivity disorder, and aggressive behaviors.[19]

Prenatal and Perinatal Period

Mothers with substance use disorders are less likely to seek prenatal care and necessary medical attention.[20] They are also at risk for co-occurring medical issues that further complicate pregnancy, including Hepatitis B, Hepatitis C, HIV, endocarditis, tetanus, abscesses, and sexually transmitted diseases.[21] Substance use during pregnancy is associated with poor outcomes, including fetal underdevelopment, premature birth, low birth weight, and other medical and developmental issues.[22] First-trimester use of illicit substances is associated with changes to fetal organs and the structure of the fetus's developing brain, while drug and alcohol use during the second and third trimesters is more likely to affect fetal brain function.

Table 1. Prenatal Effects of Drug Exposure

Substance	Emotional/Behavioral	Physical/Medical
Alcohol	Behavior problems, concentration issues, hyperactivity, learning disabilities	Fetal alcohol syndrome, abnormal facial features, growth deficiency, central nervous system problems, vision and hearing problems

16 Mary D. Salter Ainsworth & Silvia M. Bell, *Attachment, Exploration, and Separation: Illustrated by the Behavior of One-Year-Olds in a Strange Situation*, 41(1) Child Dev. 49-67 (1970).
17 *Id.*
18 Cristina Colonnesi et al., *The Relation Between Insecure Attachment and Child Anxiety: A Meta-Analytic Review*, 40(4) J. Clinical Child & Adolexcent Psychol. 630-45 (2011).
19 Karlen Lyon-Ruth, *Attachment Relationships Among Children with Aggressive Behavior Problems: The Role of Disorganized Early Attachment Patterns*, 64(1) J. Consulting & Clinical Psychol. 64 (1996).
20 Rebecca Stone, *Pregnant Women and Substance Use: Fear, Stigma, and Barriers to Care*, 3(2) Health & Just. (2015).
21 Wendy Chavkin, *Drug Addiction and Pregnancy: Policy Crossroads*, 80(4) Am. J. Pub. Health 483-87 (1990).
22 Shanti Pinto et al., *Substance Abuse During Pregnancy: Effect on Pregnancy Outcomes*, 150(2) Eur. J. Obstetrics Gynecology & Reprod. Biology 137-41 (2010).

Cigarettes	Developmental delays	Heart defects, premature birth, low birth weight, health problems, breathing problems, cleft palate, placenta problems, Sudden Infant Death Syndrome, problems with hearing and vision
Cocaine	Cognitive issues including lower IQ, information-processing problems, concentration issues	Smaller head, heart problems and urinary track problems, stroke, premature birth, low birth weight, withdrawal symptoms at birth
Opiods	Behavioral problems	Premature birth, low birth weight, placenta problems, Sudden Infant Death Syndrome, Neonatal Abstinence Syndrome
Marijuana	Behavior problems, concentration issues, developmental delays	Premature birth, low birth weight, withdrawal symptoms at birth
Methamphetamines	Developmental delays, aggression, social withdrawal	Premature birth, low birth weight

Neonatal Abstinence Syndrome

A frequent outcome of persistent opioid use during pregnancy is neonatal abstinence syndrome (NAS). NAS has increased nearly fivefold in recent years.[23] NAS occurs when a fetus is exposed to certain drugs during pregnancy and then sustains withdrawal symptoms as a newborn.[24] Symptoms of NAS include tremors, feeding difficulties, inconsolable crying, hyper-irritability, and poor sleep.[25] Newborns with NAS often require substantial medical attention.[26] Due to NAS-related symptoms, these infants can also be difficult to parent, and their symptoms can further disrupt parent-child attachment.[27] Research indicates that children with NAS whose mothers are prescribed medication-assisted treatment during pregnancy tend to fare better.[28] Compared with newborns of pregnant women who are untreated for opioid dependence, infants born to mothers receiving methadone or buprenorphine are less likely to exhibit low birth weight and other negative medical outcomes.[29] Further, women receiving medication-assisted

23 Stephen W. Patrick et al., *Increasing Incidence and Geographic Distribution of Neonatal Abstinence Syndrome: United States 2009-2012*, 35(8) Journal of Perinatology 1 (2015).

24 *Id.*

25 Scott L. Wexelblatt et al., *Opioid Neonatal Abstinence Syndrome: An Overview*, 103(6) Clinical Pharmacology & Therapeutics 979 (2018).

26 *See generally* Kelly S. McGlothen, Lisa M. Cleveland & Sara L. Gill, *"I'm Doing the Best That I Can for Her": Infant-Feeding Decisions of Mothers Receiving Medication-Assisted Treatment for an Opioid Use Disorder*, 34(3) J. Hum. Lactation (2018).

27 *Id.*

28 Tomas Binder & Blanka Vavrinkova, *Prospective Randomised Comparative Study of the Effect of Buprenorphine, Methadone and Heroin on the Course of Pregnancy, Birthweight of Newborns, Early Postpartum Adaptation and Course of the Neonatal Abstinence Syndrome (NAS) in Women Followed Up in the Outpatient Department*, 29(1) Neuroendocrinology Letters 80 (2008).

29 *Id.*

treatment, such as methadone or buprenorphine, can generally safely breastfeed, which provides health benefits to the newborn, including shorter hospital stays and reduced need for NAS-related medical treatment.[30] Breastfeeding also yields meaningful benefits to attachment.

IV. Infancy

Infancy is a vulnerable time where parents must closely read a child's signals for food, comfort, sleep, and medical needs. The period of six months to two years is particularly sensitive and can have a profound impact on attachment. Substance use can impact parenting in different ways. For example, a study from 2004 found that fathers with alcohol use disorder tended to be less warm with their infants and more likely to display negative affect.[31] In another study of parental cocaine use, LaGasse and colleagues found that cocaine-using mothers of one-month-old infants were less engaged and less flexible when feeding their children.[32]

V. Early and Middle Childhood

During early and middle childhood, children increasingly develop independence. They benefit substantially from consistency and a predictable schedule. With limited parental oversight and monitoring, children of parents with an SUD are less likely to do well in school. They may struggle with school attendance and fail to complete assignments. Further, children of parents with a substance use disorder tend to be raised in families lacking clear boundaries. Young children may assume a parental role. It is not uncommon for young children to prepare meals for themselves, take care of their infant sibling(s), and assume adult responsibilities.

VI. Adolescence

In adolescence, parent substance use disorder is associated with harsher and more punitive discipline styles and decreased supervision of children's activities. As is the case with younger children, with limited parental oversight and monitoring, adolescents are likely to have truancy issues and perform poorly in school. Parents with an SUD are less likely to assist their children with school assignments, monitor academic performance, and keep track of exams and homework. Further, lack of monitoring of the youth's sleep schedule and improper nutrition can contribute to fatigue and disengagement in school. These adolescents also tend to have deficits in social skills and less healthy peer relationships.

Notably, during adolescence, children of parents with substance use disorders are more likely to misuse substances themselves. A parent's modeling of substance misuse, increased access to substances, and insufficient monitoring can exacerbate this risk.

VII. Suggestions

Children may benefit from processing the abandonment, isolation, and worry that often accom-

30 Elisha M. Wachman et al., *Revision of Breastfeeding Guidelines in the Setting of Maternal Opioid Use Disorder: One Institution's Experience*, 32(2) J. Hum. Lactation 382-87 (2016); *See also* Elisha Wachman et al., *Association of OPRM1 and COMT Single-Nucleotide Polymorphisms with Hospital Length of Stay and Treatment of Neonatal Abstinence Syndrome*, 309 JAMA 1821, 1821-27 (2013), https://www.ncbi.nlm.nih.gov/pubmed/23632726.
31 Rina D. Eiden et al., *A Transactional Model of Parent-Infant Interactions in Alcoholic Families*, 18(4) Psychol. Addictive Behav. 350-61(2004).
32 Linda Lagasse et al., *Prenatal Drug Exposure and Maternal and Infant Feeding Behaviour*, 88(5) ADC Fetal Neonatal Edition 391-99 (2003), https://europepmc.org/backend/ptpmcrender.fcgi?accid=PMC1721596&blobtype=pdf.

panies being raised by a parent with substance misuse. It is important that these children receive care from a clinician with expertise in trauma and substance use disorders. Children may benefit from support groups to help them understand that there are other children whose parents struggle with drugs or alcohol. Notably, children should have access to at least one adult whom they can reach out to for help if they feel unsafe at home.

RESOURCES

Al-Anon/Alateen Family Groups: www.al-anon.org

Beyond Addiction: How Science and Kindness Help People Change

by Jeffrey Foote

Get Your Loved One Sober: Alternatives to Nagging, Pleading and Threatening

by Robert J. Meyers and Brenda L. Wolfe

MGH Substance Use Disorders Bridge Clinic, Boston, MA,

617-643-8281; www.massgeneral.org/substance-use-disorders-initiative

· *Motivating Substance Abusers to Enter Treatment: Working with Family*

Members by Jane Ellen Smith and Robert J. Meyers

MOAR: Massachusetts Organization for Addiction Recovery:

www.moar-recovery.org

National Association for Children of Addiction: www.nacoa.org

SMART Recovery: www.smartrecovery.org

Sober Parenting Journey in Somerville, MA:

www.parentingjourney.org/parents/sober-parenting-journey

Chapter 3: How Children are Affected by Parental Addictions and How to Support Them

Robin M. Deutsch, Ph.D., A.B.P.P., Private Practice, Wellesley, MA

I. Introduction

Children who grow up in families where a parent is misusing substances are often subject to unpredictability, instability, and sometimes chaos in the home.[33] Substance misuse affects parenting in many ways including aspects of physical caretaking such as nutrition, clothing, shelter, hygiene, routine and structure, safety and supervision, and discipline (punitive or permissive). It also affects parenting relationships with children. Parents can be emotionally disconnected or overly reactive. It is not uncommon to see a form of role reversal, in which the child tries to take care of the parent and the parent relies on the child to take over parenting functions. In addition, substance misuse often results in isolation of the family socially; as a consequence, social support is unavailable or rejected.

Robert Anda, a co-investigator of the Adverse Childhood Experiences study (1998), notes that growing up with parental addiction and the chaos that surrounds it contributes to toxic stress. Toxic stress, in turn, affects brain development, resulting in children's difficulties in regulating and managing emotions and accurately processing information. Further, while growing up with someone in the home with substance misuse is one of the ten Adverse Childhood Experiences (ACE), it is common to have more than one ACE when a parent or caregiver in the home has an addiction. Once a home environment is functioning poorly, additional risks of witnessing or experiencing domestic violence, emotional, physical, or sexual maltreatment greatly increases.

Though approximately one in eight children has a parent with an SUD,[34] most children believe they are the only one dealing with this problem. They tend to blame themselves and believe that if they had done something differently this would not have happened. They do not want anyone to come to their home because they are afraid of the chaos and ashamed of their parent's behav-

33 Ruth McGovern et al., *The Association Between Adverse Child Health, Psychological, Educational and Social Outcomes, and Nondependent Parental Substance: A Rapid Evidence Assessment*, 21(3) Trauma, Violence, & Abuse 470-83 (2020).

34 Rachel N. Lipari & Struther L. Van Horn, The CBHS Report: Children Living with Parents who Have a Substance Use Disorder, Substance Abuse and Mental Health Services Administration (August 24, 2017), https://www.samhsa.gov/data/sites/default/files/report_3223/ShortReport-3223.pdf.

ior.

Specifically, preschool-aged children often engage in magical thinking, believing that they are responsible for things that happen and affect them. They want to be powerful and to avoid feelings of helplessness. Children this age may try to make everything all right and become afraid of leaving their SUD parent, fearing what will happen when they are gone. They may react with separation anxiety or increased aggression. They need to know their parent has a problem that has nothing to do with them, and that there is nothing they can do to fix it.

As school-aged children get older, they may become more rule-bound and moralistic. They may judge the parent with a substance use disorder, which may result in anger, aggression, and even rejection of the parent. They may also be afraid to leave a SUD parent and refuse to attend school or fail to develop healthy peer relationships.

Adolescents may respond in many ways. They may follow in the footsteps of their parent and have a SUD themselves, or they may distance themselves from that parent and rely on peers for guidance, establishing their identity as very separate from their parent. This is a time of increased risk for kids. Without the guidance of an adult, adolescents may not adequately assess risks and ultimately make poor choices for themselves.

II. What Do Children Need to Know?

Children need to know that substance use disorder is a disease, it is not their fault, and it may cause the parent to act in ways that are not the result of anything the child has done. They need to know that many people have this disease and that there are many other kids who have a SUD parent. Children also need to know that SUD is not a secret and that there is someone they can talk to about this problem, whether that person is a teacher, counselor, family member, or friend. Because substance misuse in the home can create safety concerns, including violence between adults, violence toward the child, or inadequate physical and emotional care, children need to know that their safety is primary and that there are people who can help them remain safe.

Children need education in schools and other institutions about the effects of substance misuse on parenting, which should emphasize that talking about this problem is the best way to help themselves in these difficult situations. The most important point to communicate is that they are not alone, and that they cannot fix the problem, but they can take steps to take care of themselves.

The National Association for Children of Alcoholics suggests that children dealing with family addiction learn and use the following "7 Cs of Addiction"[35]:

I didn't cause it.
I can't cure it.
I can't control it.
I can care for myself
By communicating my feelings,

35 *Facts for You*, Nat'l Ass'n for Child. of Addiction, https://nacoa.org/families/just-4-kids/ (last visited May 14, 2020).

Making healthy choices, and
By celebrating myself.

Children who have parents or caregivers with addiction disorders need resources to help them build coping skills to manage this stressful experience and to help them live their own addiction-free life. Strength-based interventions that are used to build resilience are useful. These include instilling hope and encouragement, finding practical solutions to presenting problems, building strength and competence, and fostering empowerment and change.[36] School and community support networks should encourage and facilitate activities that support physical health, such as exercise and nutrition, and activities that support emotional health, including peer support, stress- reduction techniques such as mindfulness and centering activities, and problem-solving skills to manage the problem and source of stress. We also know that having a sense of purpose and meaning and committing to a personal mission builds resilience.[37]

For parents with a substance use disorder, the message is this: Talk to your children. Explain that addiction is a disease. Give them permission to find social, emotional, and physical support. Tap into community resources. Help them find ways to reduce stress and build coping skills and resilience. Consider family therapy. Children need to know that they are not at fault.

RESOURCES

Center on the Developing Child at Harvard University: www.developingchild.harvard.edu

Substance Abuse and Mental Health Services Administration: www.samhsa.gov

36 *See generally* Nat'l Child Traumatic Stress Network, www.nctsnet.org (last visited May 14, 2020).
37 Substance Misuse and Mental Health Services Administration (SAMSHA), Trauma-Informed Care in Behavioral Health Services, Treatment Improvement Protocol (TIP) Series 57 (2014), https://store.samhsa.gov/product/TIP-57-Trauma-Informed-Care-in-Behavioral-Health-Services/SMA14-4816.

Chapter 4: Supervised Visitation for Substance-Misusing Parents

Jordana Douglas, Esq., Ropes & Gray, LLP
Stephanie Tabashneck, Psy.D., Esq. Private Practice, Wellesley, MA

I. Introduction

Of the many relationships formed over the course of one's life, the relationship between a parent and child is among the most important.[38] As early as infancy, children are reliant on bonding with caregivers to promote growth and psychological well-being. Children who have been separated from their parents or fail to create this essential bond may exhibit a number of problems later in life, including mental health issues, substance-use issues, employment problems, and other negative outcomes.[39]

Court professionals play an important role in family court cases involving parental substance use. Parents who engage in substance use may require limitations and supervision when bonding, caring for, or spending time with their child. Assuming that maintaining the parent-child relationship is an objective, courts should proactively seek to preserve this relationship.

To the extent that a child has a meaningful pre-existing relationship with their parent, and it is not safe for the parent to have unsupervised contact with the child, some form of supervised visitation or avenue for continued connection should be implemented immediately. The level of supervision required and the precise requirements for visitation must be determined on an individual and ongoing basis. If in-person visitation is not a viable option, court practitioners should consider intermediary measures, such as letters, videos, phone calls, videoconferencing, FaceTime, and so on.[40] Understanding the importance of the parent-child relationship and ensuring consistent contact are essential to the relationship's preservation.

II. Utilizing Supervision to Promote and Foster the Parent-Child Relationship

38 Laurence Steinberg, *Parent-Child Relationships: Infancy, Toddlerhood, Preschool, School Age, Adolescence, Adults*, Psychology, https://psychology.jrank.org/pages/472/Parent-Child-Relationships.html (last visited April 16, 2020).
39 Tiffany Field, *Attachment and Separation in Young Children*, 47 Ann. Rev. Psychol. 541 (1996).
40 Depending on the developmental stage of the child, children may struggle with phone and videoconferencing interactions. Behaviors during electronic contact, even within the context of a relatively healthy parent-child relationship, could include inattention, resistance, and distress. This is to be expected and is often best navigated by the caregiver actively facilitating the parent-child interaction with planning, preparation, and encouragement.

Unnecessary supervision requirements and court-imposed restrictions can have negative implications for both children and parents. When imposing restrictions, it is important to remember that the ultimate goal of supervision interventions is to maintain the child's safety, foster a healthy parent-child relationship, and, depending on the age of the child, promote healthy attachment.

Court practitioners should view cases involving substance using parents with compassion. Addiction is a brain-based condition which is associated with periods of repeated relapses and setbacks. A common misconception about substance misuse is that the only solution to using substances is not using them. However, when supervision or other protections are in place, abstinence is not required for a parent to maintain a healthy and safe relationship with their child. Indeed, in many cases it is more harmful to the child to abruptly terminate parent-child contact than to maintain the child's relationship with a parent who at times misuses substances. It is impractical and often ineffective to assign blame when a parent relapses or shows signs of regression, as this can increase stigma and shame, two factors that jeopardize recovery. Rather, court practitioners should acknowledge the individual journey that each parent is on, work with the parent to identify what is and is not working in terms of their recovery, troubleshoot setbacks, and meet the parent where they are.

As indicated above, best practice does not require abstinence from a parent as a prerequisite for supervision. Rather, supervision requires that a parent be able to participate in a sober, substance-free visit with their child. This may be best implemented by requiring parents to complete a drug test prior to a visitation session if the substance is alcohol, or for the supervisor to have a brief conversation with the parent to ensure the parent is not under the influence and therefore compromised.[41] Parents who are unable to remain sober for supervised visitation should still remain in contact with their child in other ways, such as by writing a letter, recording a video for the child during a period of sobriety, or participating in a phone or video call with the child. Promoting continued communication between the parent and the child can reduce the risk of separation-related harm to children, in particular for those who are repeatedly separated from their parents.

III. When Should Supervised Visitation be Required?

Notably, most parents with a Substance Use Disorder are capable of maintaining a relationship with their child. When safe to do so, maintaining contact and supporting a healthy, sustainable relationship between parents and their child should be a key objective in cases involving a substance misusing parent.[42] Specifically, court practitioners should only impose supervision, restrictions, or suspend visitations when it is determined that unsupervised visitation is not in the best interest of the child.[43] These restrictions and/or limitations should be created with the ultimate goal of fostering a healthy parent-child relationship that may eventually be sustained without court intervention.

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41 Drug testing is not an accurate measure of sobriety for all substances. Further, a parent may test positive for a drug that they have not used in months (e.g., alcohol may show up in hair for up to 90 days) or weeks (e.g., cocaine may show up in urine for up to two weeks) so drug testing often does not make sense for determining if a *particular visit* should occur.

42 *See Robinson v. Robinson*, 2020 Mass. App. Unpub. LEXIS 244, *4-5 (Mass. App. Ct. April 8, 2020) ("We have stated that "[t]he best interests of a child is the overarching principle that governs custody disputes in the Commonwealth."); McKnight v. Fisher, 2018 Mass. App. Unpub. LEXIS 120, *11-12 (Mass. App. Ct. February 6, 2018) ("In custody matters, the touchstone inquiry [is] . . . what is 'best for the child.'") (internal citations omitted).

43 *Schechter v. Schechter*, 88 Mass. App. Ct. 239, 247-48 (Mass. App. Ct. September 9, 2015).

In considering supervised visitation, court practitioners must balance a parent's fundamental, constitutionally protected interest in their relationship with their child with the child's best interest.[44] The Court in *S.P v. B.D.* acknowledged this delicate balance by ordering supervised visitation as a means to both "ensure the safety of the children and provide the best opportunity for the father and children to develop a strong bond."[45] Key considerations in balancing these interests include the parent's role as a caretaker, the bond formed between the parent and child, the child's need for stability and continuity, the decision-making capabilities of each parent to meet the child's needs, the living arrangements and lifestyles of each parent, and how these factors affect the child.[46] In addition, it is important to consider that children who experience separation from their caregiver, abandonment, and neglect early on, with insufficient subsequent caregiving, may experience irreparable delays in cognitive function, motor skills, and language development; deficits in socioemotional behaviors, and psychiatric disorders.[47]

Factors to consider when determining whether supervised parenting time is necessary and what the nature of the supervised visitation should be span well beyond the use or misuse of substances and the type of substance used. Court practitioners should consider substance use within the context of several factors, including:

- Parenting Skills
    - o The practitioner should consider whether parents are able to:[48]
        - Meet the child's health and development needs
        - Put the child's needs first
        - Provide consistent and routine care
        - Set boundaries
        - Acknowledge problems and engage with supportive services

- Psychological Conditions
    - o At least 75% of substance-using parents have a co-existing psychological condition such as depression, anxiety, trauma, or a personality disorder.
    - o Court practitioners should consider underlying psychological conditions and their effect on the child.

- Involvement in Treatment
    - o Court practitioners should consider whether the parent is currently involved in treatment, what treatment the parent has completed, and plans are in place for future treatment.
    - o Treatment can include:
        - Inpatient hospitalization
        - Partial hospitalization
        - Intensive outpatient treatment
        - Outpatient therapy

44 *S.P. v. B.D.*, 94 Mass. App. Ct. 1122, 123 N.E.3d 802 (2019).
45 *Id.* (internal citations omitted).
46 *Robinson v. Robinson*, 2020 Mass. App. Unpub. LEXIS 244, *4-5 (Mass. App. Ct. April 8, 2020) (internal citations omitted).
47 Kirsten Weir, *The Lasting Impact of Neglect: Psychologists are Studying How Early Deprivation Harms Children — and How Best to Help Those Who Have Suffered from Neglect*, 45 Am. Psychol. Ass'n 36 (2014), https://www.apa.org/monitor/2014/06/neglect.
48 NSPCC, *Assessing Parenting Capacity Fact Sheet* (February 2014), http://www.theministryofparenting.com/wp-content/uploads/2015/08/factsheet-assessing-parenting-capacity8.pdf.

Peer-support groups (e.g., Alcoholics Anonymous, Narcotics Anonymous)
SMART Recovery attendance
Group therapy
Medication Assisted Treatment

- If a parent is not currently engaged in treatment, consider:
  - What treatment the parent is willing to participate in?
  - Are they motivated to complete the treatment successfully?[49]
  - What ways can they maintain a connection to the child?

- Additional factors:[50]
  - Child's developmental needs
  - Child's attachment to the parent
  - Support of extended family
  - Stable housing
  - Income
  - Employment
  - Connection with community resources

IV. How to Implement Supervised Visitation

a. Court Orders and Stipulations

Court orders and stipulations for supervised visitation should include, at the minimum:

- Reason for supervision
- Name of supervisor
- Frequency, duration, and restrictions (if any)
- Parenting schedule
- Communication and information sharing between parents
- Review date
- Assignment of responsibility for payment
- Location where the visits would take place
- Explicit criteria to modify or "step up" supervision
- Explicit criteria to terminate supervision

b. Determining Who Will Supervise

A supervisor may be a non-professional, such as a friend, relative, or suitable third party, or a professional, such as a person or agency that is paid for supervised visitation services. When a non-professional supervisor such as a family friend can adequately maintain safety during a visit, this is generally preferred, as it offers more flexibility and natural parent-child interactions. A child's ability to connect with their parent may be inhibited by the presence of a stranger.

- Financial Considerations
  - Non-professional supervision by a suitable third party should be implemented

49 Notably, due to their illness, a parent with a Substance Use Disorder is likely to experience waxing and waning motivation to engage in treatment. It is imperative that treatment is immediately available for the parent at the moment that they decide to get help. See Susan Aud et al., The Condition of Education 2010, https://nces.ed.gov/pubs2010/2010028.pdf.

50 *See generally* HM Government, *Working Together to Safeguard Children: A Guide to Inter-Agency Working to Safeguard and Promote the Welfare of Children* (2013), https://webarchive.nationalarchives.gov.uk/20130403204422/https://www.education.gov.uk/publications/eOrderingDownload/Working%20Together%202013.pdf.

when reasonable, as professional supervisors can be costly and often offer limited hours.

- o If finances are a concern, court practitioners should give significant thought to whether a family member or friend can supervise so as not to unintentionally interfere with the child's ability to maintain and access contact with their parent.

- Environmental Considerations
  - o Community visits are preferable when possible.
  - o Non-professional supervisors such as high-functioning friends or family already known to the child are likely to make the child more comfortable during visitation.
  - o Supervised visitation centers provide a higher level of safety and oversight but also can be an uncomfortable and unfamiliar venue for parenting time. Supervised visitation centers should only be used as a last resort. Due to limited availability, visitation centers often impose strict and inflexible rules and time limits on supervised parenting time. If the child requires more contact with their parent to sustain a healthy relationship, the visitation center may not be able to accommodate additional hours.
- Safety Considerations
  - o Any supervisor chosen must be able to intervene if the child's safety is at risk or the parent is under the influence of substances during the visit.

c. Determining the Level of Supervision

Supervision is generally unnecessary for a parent who has engaged in infrequent substance use of a generally non-lethal drug (e.g., cocaine use once every other month over a 12-month period when the child was not in their care) or experimental use of a substance (e.g., LSD once at a social function). For an individual with an active substance use disorder,[51] however, the Court should consider requiring supervised parenting time for an initial period of three months. Supervised visitation should be implemented on a "continuum of access" scale, allowing for flexibility and growth in accordance with a parent's recovery. After the initial three-month period, the level of supervision should be revisited and altered if there is progress. Visitation and restrictions should be reassessed every 30 days until supervision is no longer necessary to ensure the health and safety of the child.

- Deciding where on the spectrum supervision should fall, consider:
  - o Severity of the substance use disorder
  - o Length of the substance use disorder
  - o Nature of the parent's substance use, including whether the parent uses when the child is in the their care
  - o Current relationship between the parent and child

51 The central aspect of a substance use disorder is continued use of the substance despite significant negative life consequences. Symptoms which may or may not be present include using larger amounts of the substance over time, failing at efforts to stop or control use, excessive amounts of time dedicated to obtaining, using, or recovering from the substance, strong urges to use, use resulting in failure to accomplish major life obligations at work, school, or home, continued use despite interpersonal problems, reducing or stopping important activities due to substance use, a need for larger amounts of substances over time or diminished effect of the substance, and withdrawal. *See* American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders (5th Ed. 2013).

- Overdose history and whether the overdose occurred when the child was in the parent's care
- Nature of relapse

  For example, if a parent relapses one time or after an extended period of sobriety (e.g., four to six months) and immediately communicates the relapse to their therapist, other parent, sponsor, or support system, then reimplementation of supervised visitation may be unnecessary. However, if a parent has a prolonged relapse (e.g., two weeks with failure to communicate the relapse occurred), supervised visitation is more likely to be required to ensure the safety of the child.

Continuum of Access

- Professionally supervised contact at a Visitation Center
- Professionally supervised contact in the community
- Parenting time supervised by a non-professional supervisor
- Parenting time in the community with restrictions on transporting the child
- Parenting time at a neutral family member's home with familial oversight
- Parenting time at a neutral family member's home including overnight visits
- Unsupervised parenting time during the day paired with drug and/or alcohol testing
- Unsupervised parenting time at night paired with drug and/or alcohol testing

d. Case Excerpts with Recommended Supervisions

Fact Pattern #1: Mr. Smith

- Facts
  - Mr. Smith has an Alcohol Use Disorder and was observed to be intoxicated during parenting time on approximately six occasions. He has been sober for months, regularly attends SMART Recovery twice a week, and attends psycho therapy once a week. All of Mr. Smith's previous breathalyzer screens have been negative. He has no history of driving with the child while under the influence.
  - Mr. Smith has a three (3) year old daughter.
  - Mr. Smith was previously a 50/50 caregiver.
- Recommended Supervision Plan
  - It is recommended that Mr. Smith's parenting time be supervised for the first half hour of each visit by a family member or friend for the next two (2) months, until Mr. Smith attains six (6) months of sobriety. Mr. Smith will be required to breathalyze before and after his parenting time.
  - After six (6) months of sobriety, Mr. Smith may enjoy parenting time without supervision. However, he should continue to submit to alcohol screens until one (1) year of sobriety.

Fact Pattern #2: Ms. Johnson

- Facts
  - Ms. Johnson has a history of Opioid Use Disorder. She has used opioids on and off for the last three years, and she recently overdosed on fentanyl. This was her third overdose in the past year. She has successfully completed detox and a structured outpatient addiction program (SOAP).
  - Ms. Johnson has a 10-year-old daughter, however their relationship is strained. Ms. Johnson missed the last four community visits with her daughter, and her

daughter expressed disappointment and sadness.

- Recommended Supervision Plan
    - o The Court should begin by considering whether Ms. Johnson has received adequate treatment for her Opioid Use Disorder, including whether Ms. Johnson has had access to Medication-Assisted Treatments, such as methadone or buprenorphine. It is unlikely that Ms. Johnson will be able to effectively address her Opioid Use Disorder without such treatment.
    - o With regard to Ms. Johnson's relationship with her daughter, the Court should work with Ms. Johnson to find alternative ways to maintain a healthy relationship. Given that Ms. Johnson has missed the last four visits, the Court should consider allowing Ms. Johnson to write letters or record videos to the child in the absence of a physical visit. In addition, the caregiver for Ms. Johnson's daughter should send pictures and videos of the daughter to Ms. Johnson.
    - o Ms. Johnson's case is more difficult, given the long periods of sobriety and sudden relapses common with an Opioid Use Disorder. Regardless, it is important to support the parent-child relationship. As such, given the negative impact of Ms. Johnson's "no-shows" on her daughter, restrictions on in-person visitation should be implemented until Ms. Johnson can demonstrate reliability (e.g., Ms. Johnson could be asked to call in every day at 9:00 a.m. to check in. If she is able to do this for two weeks, visits could tentatively resume). In the meantime, other types of contact should be implemented, such as phone calls, letters, and video calls.

V. How to Safely Lift Supervised Visitation Requirements

Court practitioners should cultivate an environment of sharing between parents, probation officers, attorneys, and the Court. Restrictions on a parent-child relationship are best monitored and assessed when the substance-misusing parent is able to acknowledge a relapse without the overwhelming fear of losing all contact with their child.

The level of supervision and the extent of time necessary to protect the child's health and safety will vary from family to family. There is no one-size-fits-all model – court practitioners must revisit the order of supervision frequently to ensure that a parent's recovery efforts provide tangible results. Goals should be reachable and should not solely revolve around abstinence. Other important incremental goals may include a decrease in use, a decrease in potency of the drug used, changes in frequency of use, safety of use, open communication about use, and assumption of responsibility for one's actions.

When revisiting orders of supervised visitation, court practitioners should be cognizant that individuals with a substance use disorder heavily rely on interim goals as motivation to achieve and sustain recovery. For an individual without a substance use disorder, the "future" includes the next four to five years.[52] For an individual with a substance use disorder, the "future" is merely the next seven days. Therefore, separating a substance-misusing parent from their child for months at a time may discourage the parent and hinder their ability to reach their goals. This decrease in motivation by the parent can lead the parent to disengage from the process, which

52 Nancy M. Petry, Warren K. Bickel & Martha Arnett, *Shortened Time Horizons and Insensitivity to Future Consequences in Heroin Addicts*, 93 Addiction 5 (2002), https://doi.org/10.1046/j.1360-0443.1998.9357298.x.

can have toxic effects on the child, who has lost access to their parent. As the ultimate goal of court involvement is to protect the best interest of the child, court practitioners should carefully consider the impact of constraints on parenting time for both the parent and the child. Notably, unnecessary restrictions and supervision for a parent, in particular for younger children, can create barriers to the child's attachment, ultimately leading to irreparable harm and poor life outcomes for the child.

RESOURCES

Suchman, N. E., Pajulo, M., & Mayes, L. C. (2013). *Parenting and Substance Abuse: Developmental Approaches to Intervention* (1st ed.). Oxford University Press.

Guidelines for Court Practices for Supervised Visitation: www.mass.gov/files/documents/2018/11/29/supervised-visitation-guidelinesfinal%20%281%29.pdf

Standards for Supervised Visitation Practice: www.svnworldwideorg/assets/docs/standards.pdf

Chapter 5: Crafting Parenting Plans in Cases Involving Substance Use

Jessica Greenwald O'Brien, Ph.D., Director, Center of Excellence for Children, Families and the Law and the Child and Family Forensic Evaluation Service

I. Introduction

When allegations of substance use are made against a parent in the context of a divorce, separation, or child welfare matter, a layer of challenge is added to the task of crafting an appropriate parent-child contact plan. While the typical goals of a parenting plan must continue to be met, the focus on safety and well-being of the child(ren) is heightened with a parent who actively uses or is recently in recovery, or when the truth about their level of use remains uncertain.

II. Components of a Thorough Parenting Plan

A parenting plan is a vehicle to describe all aspects of the parenting arrangements for a child. Research shows that children benefit from maintaining a relationship with both parents.[53] As such, the goal of a typical parenting plan is for a child to experience quality parenting and the best resources both parents have to offer. This should occur in the context of low parental conflict, with as much frequency as is feasible and safe, so long as it promotes the child's well-being.

A good parenting plan goes beyond simple allocation of time, and describes:[54]

- The nature and quality of parent-child time, including expected activities and allowed interactions. What is a parent responsible for during parenting time (e.g., homework help, appointments, emergencies, extracurricular participation)? Who can be present during parenting time – including new partners?
- The resources needed to support a successful parent-child relationship and co-parenting relationship. This could include therapy, parenting plan monitors/parent coordination, family/friend supports, and parenting education.

53 Leslie Drozd et al., Parenting Plan Evaluations: Applied Research for the Family Court 170 (2nd Ed. 2016).

54 Basic Parenting Plan Guide for Parents, Children & Families, Oregon Judicial Branch, https://www.courts.oregon.gov/programs/family/children/Pages/parenting-plan-guide.aspx (last visited May 14, 2020); Mass. Ass'n fam. Conciliation Cts, Planning for Shared Parenting: A Guide for Parents Living Apart (2005), https://www.masslegalhelp.org/children-and-families/afcc-shared-parenting-planning.pdf; Parental Rights and Responsibilities and Parent Child Contact, Vermont Judiciary, https://www.vermontjudiciary.org/family/parental-rights-and-responsibilities-and-parent-child-contact (last visited May 14, 2020).

- Arrangements for parent-child communications. The form and frequency of parent-child contact (e.g., phone, email, video chat, text, cards/gifts), and whose discretion governs this contact should be identified.
- Arrangements for co-parent communications about the child. The form, frequency, purpose, content, and tone of communications between parents, along with a strategy for a non-responsive/communicative parent should be identified.
- Agreements around legal custody. Who has decision-making authority for which areas of the child's life?
- The parenting time for each parent. How does time get allocated between parents on a routine basis, during holidays, and in special circumstances? Is time supervised or unsupervised? How are transitions handled?

III. Necessity to Build a Nexus between Substance Use and Parenting

The Massachusetts courts have made it clear that evidence of substance use, in the absence of any evidence of harm to the child, does not constitute parental unfitness. Therefore, it is essential to determine the nexus between the use of substances, the lifestyle surrounding the use of substances, and the impact on parenting and the child's functioning.[55] Key characteristics of a substance user's patterns of use that could have particular bearing on parenting include:

- Does the parent use during parenting time? If yes, does the parent use less, use a safer substance, or ensure there are other sober/abstinent caregivers present? Are the child's presence and needs considered in use decisions and behaviors?
- How does the parent's substance use affect the parent, and in turn, affect their parenting? Are there problems in judgment, interpersonal and disciplinary harshness, attunement/attentiveness, level of consciousness, role reversal, absenteeism, etc.?
- Does the parent's use put the child's safety secondary to his/her/their own substance use needs?
- Does the parent have any insight into his/her/their use of substances as it impacts the child?
- Does the parent take any protective steps to minimize the child's exposure to harm?
- If in recovery, does the parent have a plan for the child should a recurrence (relapse) occur?

IV. Goals of Parenting Plans for Substance Using Parent or Parents in Recent Recovery

The parenting plan for a family with a substance using parent, or a parent in recent recovery, should be a direct response to the variables identified in the nexus analysis described above. The specific parenting plans for substance using parents should attempt to:

- Ensure positive connections to both parents in a safe context
- Respond to the child's typical developmental and temperamental needs
- Ensure that the child's basic needs get met, and reduce the risk of neglect
- Respond to the child's needs that arise from growing up with a parent who misuses substances, and the associated challenges
- Support the child's coping and resilience
- Reduce the risk of physical or sexual harm to the child
- Reduce the risk of exposure to emotional harm (e.g., intimate partner violence, chaos, unsafe and unsavory people, developmentally inappropriate knowledge of drug activity

55 *Adoption of Katharine*, 42 Mass. App. Ct. 25 (1997).

and paraphernalia)
- Reduce the potential for short- and long-term mental health consequences (depression/sadness, helplessness, isolation, negative self-concept, other psychological symptoms, development of substance misuse issues, and other risk-taking)
- Minimize exposure to parental unreliability around parent-child contact
- Minimize instability related to parental unemployment, homelessness, financial stress, and food insecurity

Notably absent from the goals of such parenting plans is the attempt to punish a parent for their substance use behavior. A parenting plan should be cast in the language of meeting the needs and protecting the well-being of the child, not blaming the parent for their disease. With that said, a good parenting plan will have an accountability and monitoring component – one that appreciates the realities of relapse potential – that can shift parenting time when relapse occurs to address the well-being of the child. Recurrence (relapse) is an acknowledged and normative part of substance use recovery and does not automatically imply that a parent should not have contact with their child or a substantial decrease in contact. A case-by-case analysis of the parent's relapse and the child's needs and functioning shape the parenting plan response to a relapse.

V. Specific Considerations for a Parenting Plans with Substance Using or Recently Recovering Parents

As noted above, there are several elements to a thorough parenting plan. In this section, these elements will be reviewed with specific attention to how they might be addressed with a substance using parent or parent in recent recovery.

Time with each parent
The first question is always about safety. Court practitioners should consider whether the parent's ongoing use or recent recovery poses a risk to the child. If the parent's use significantly compromises their judgment and the child's safety or exposes the child to direct harm, parenting time should be considered only incrementally. It should begin with a period of limited supervision or no contact, with frequent check-ins for progress.

A "step-up" plan or a plan that incrementally increases access between parent and child is typically required. At each juncture where additional time or a relaxation in supervision is considered, a risk-benefit analysis should be conducted for the child: What are the potential harms to the child of increased contact with the parent, or not seeing the parent versus the benefit of more time with the parent and the harm of not seeing the parent? This kind of analysis recognizes the potential benefits of the relationship between the child and the parent with a substance use disorder. It allows for the creative maintenance of that relationship as long as the child's safety and well-being are preserved. For example, even a parent who has not achieved ongoing sobriety might be able to have contact if they can demonstrate sobriety directly before parenting time blocks.

At each juncture thereafter, when additional time is considered, information should be gathered from multiple sources to appraise:

- the using parent or formerly using parent's current functioning, engagement with sobriety activities, and substance use and mental health treatment

- the child's current level of functioning, and level of resilience or distress in response to parenting time[56]
- the co-parent's contributions to the success or sabotage of the using parent's parenting time

If progress is being made by the using/recently recovering parent, the child is not unduly symptomatic, there is reasonable stability in the child's life, and there is no other change in the risk/benefit analysis for the child, an incremental increase in time should be considered.[57]

Dr. Stephanie Tabashneck has recommended that a template of parenting time be characterized by blocks of supervised time, punctuated with briefer periods of unsupervised time.[58] These unsupervised periods often take place in the morning, when risk exposure for the child may be reduced. Afternoon, evening, and eventual overnights are periods that might create increased vulnerability for the using or recently recovering parent, adding a level of risk for the child(ren), thus they are supervised. As the "step-up" plan proceeds, the stretch of unsupervised time expands with each increment. The supervised stretches are shortened over time, with the overnight periods being the last to shift to unsupervised status.

It should be noted that supervision is not implemented as a mechanism for punishment for a parent's behavior. It is established to ensure the safety of the child(ren), provide mechanisms of accountability for the using or recently recovering parent, and keep a set of eyes on the child's functioning. Supervision should be implemented with an accompanying strategy for the reduction in supervision requirements. This can include longer periods of sustained sobriety, learned parenting skills, the avoidance of prior concerning behaviors, or the demonstration of appropriate interactions with the co-parent.

Other important, substance use-specific factors to consider with regard to time allocations include:

- Each parent's past history of parental involvement and responsibilities. To what extent has the substance using or recently recovering parent been involved in parenting the child(ren) in the past?
- The developmental level of the child. What cognitive, linguistic, and emotional resources does the child have for managing or coping with the substance-using or recently recovering parent's parenting challenges?
- The temperament of the child. Is the child rigid and sensitive or flexible and adaptable? Is the child hyperactive or low energy? Moody and negative or joyful and optimistic? These qualities factor into both how the child can manage the parent's challenges or mis steps, but also how well the parent can manage parenting tasks related to the child's style and personality.

Finally, time arrangements should always include a "Plan B," if the substance using/recently recovering parent either is not sober for the parenting time block, relapses after a period of sobriety, or feels at risk for relapse. Clearly, an inebriated or intoxicated parent should not have contact with the child(ren), and a pattern of inability to meet this basic requirement would warrant a modification of the parenting plan. The sober parent who has relapsed or feels at risk

56 The child's distress may be caused by several factors, including, for example, boredom, anxiety, fear, or allegiance to the custodial caregiver.

57 Marsha Kline Pruett et al., Considerations for Step-Up Planning: When and How to Determine the Right Time (2018), https://www.afccnet.org/Portals/0/Step%20up%20AFCC%20Webinar-handout.pdf; Leslie Drozd et al., Parenting Plan Evaluations: Applied Research for the Family Court 170 (2nd Ed. 2016).

58 Please see appendix for a sample incremental parenting plan.

of relapse should have a means of notifying the other parent and make alternate arrangements for their parenting time (e.g., either leaving the child with the co-parent or with a backup, agreed-upon caregiver).

Content of Time with Each Parent
Content of time refers to what activities should (e.g., taking a child to soccer practice or piano lessons or attending parent-teacher conferences) and cannot (e.g., drug use, leaving a child unsupervised) occur during parenting time. In the case of a substance-misusing or recently recovering parent, these provisions might also govern whether the parent can drive with the child or what specifications might need to be met in order to drive with the child (e.g., car-installed breathalyzer monitoring device).

These provisions also identify who can (e.g., grandparent) and cannot (e.g., former or present drug-using associates) be present during parenting time. Whether or not a new significant other may be introduced to the child should also be addressed. Along with the typical cautions for exposing children too soon to new partners, for substance-using/newly recovering parents there are the additional concerns of not straining recently achieved sobriety and avoiding big changes or additional instability for children.

When parent-child contact is curtailed, one way of preserving the relationship between the child(ren) and the substance-using parent is the preservation of the child(ren)'s relationship to that parent's extended family. There can be safe and structured ways that extended family contact can happen, whether that involves establishing court-ordered rules, supervision, or informal accountability channels. Such contact allows the child(ren) to recognize the value of family and that half of the child's identity, to diminish the perception of punishment, and to build more supports for the child(ren).

Parent-Child Communications
When contact may be curtailed for a period of time (e.g., the parent is in treatment that does not allow for outside communications, or parenting time has been stepped down due to relapse), the use of other means of maintaining the parent-child relationship should be actively brainstormed and promoted. Unless there is a professional belief that other forms of communication could cause harm to the child (e.g., the parent has previously misused communications with the child), considerations of phone, video chat, photos, letters, pre-made videos, or other creative strategies should be explored. The method and frequency must be developmentally appropriate, but ongoing communication connotes to the child the importance of the relationship and the ongoing investment in the relationship by both the parent and co-parent. It also contributes to the maintenance of the real-time relationship, which can be particularly important for a young child, with a developmentally poorer sense of time.

Co-parent Communications
Of particular importance is that the substance-using/recently recovering parent feels it is safe to disclose, without reprisal, any concerns about their own mental health status, apprehensions about relapse, or concerns about the ability to care for the child(ren). The willingness to do so should be considered insightful, constructive, and courageous, even if it means that parenting time needs to be limited, or supervision increased for a time. If a parent has these concerns, they should make their concerns known to the co-parent, along with the parenting plan monitor and any relevant treating professionals, in order to access resources to prevent a relapse. The co-parent should be educated about appropriate responses both to the substance-using parent and to

the child(ren).[59]

Should the parent relapse, they should also be able to communicate this to the co-parent, parenting plan monitor, and relevant treatment providers without fear of reprisal. If feasible, both parents should find a way to communicate the appropriate aspects of the using parent's situation to the child(ren), and the implications for parent-child contact over the next period of time.

If reliability around parenting time has been an issue, then the substance using/recently recovering parent should be required to confirm with the co-parent prior to each parenting time block.

The communications regimen should ensure that emergency contact information as well as a backup emergency contact for each parent is available to the other. There should also be an arrangement such that if one parent does not respond to the other within a certain amount of time, there is a backup plan. In non–substance use cases, this often takes the form of one parent asking for the input or an answer from the other to make a decision, and the other parent chooses not to respond. In that situation, the parenting plan could dictate that in the absence of a response after 48 hours, the first parent can make the decision solo. In a substance-use case, there might be increased concern for a parent who falls off the communications grid, especially if that occurs during active parenting time. The parenting plan might elucidate a secondary communication route to get information about the children or the substance-using/recently recovering parent (within appropriate reason). For example, an emergency contact could be provided. That person, agreed to by both parties in advance, could check in with the substance-using/recently recovering parent and report the status of the children's welfare back to the other parent.

VI. Resources to Facilitate a Successful Parenting Plan

A "step-up" plan for a parent with a substance-use history will routinely require the involvement of a parenting plan monitor/parent coordinator who has access to several sources of information about all members of the family. It is that monitor who should be vested with the authority to implement the "step-up" process, or "step-downs" if needed.

Other resources that would support the success of a parenting plan could include:

- Substance use treatment for the parent at the level of intensity that is warranted, including medication-assisted treatment and recovery coaching
- Individual mental health treatment for the substance using parent, co-parent, or child(ren) if there are mental health issues
- Family therapy if there are post-separation/divorce, high conflict, or family substance use dynamics to be addressed between and among family members
- Drug testing (e.g., through Probation), or alcohol monitoring (e.g., Soberlink)
- Self-help and peer support groups such as Alcoholics Anonymous or Narcotics Anonymous, and/or SMART Recovery
- Parent education about the impacts of conflict or substance use on children
- Supportive family and friends who can serve as eyes on the child, respite coverage for either parent, supportive listeners for either parent and/or non-professional supervisors where appropriate

59 Please see appendix for a sample relapse plan.

RESOURCES

Association of Family and Conciliation Courts: www.afccnet.org

Learn to Cope: www.learn2cope.org

Moyer, S. (2004). *Child custody arrangements: Their characteristics and outcomes*. Department of Justice Canada: www.justice.gc.ca/eng/rp-pr/fl-lf/parent/2004_3/pdf/2004_3e.pdf

National Association for Children of Addiction: www.nacoa.org_

Chapter 6: Medication-Assisted Treatment

Ruth Potee, M.D, Fellow of the American Society of Addiction Medicine
Stephanie Tabashneck, Psy.D., Esq. Private Practice, Wellesley, MA

"Medication-assisted treatment saves lives while increasing the chances a person will remain in treatment and learn the skills and build the networks necessary for long-term recovery."-Michael Botticelli, Director of the National Drug Control Policy

"Studies show that people with opioid dependence who follow detoxification with no medication are very likely to return to drug use, yet many treatment programs have been slow to accept medications that have proven to be safe and effective."-Nora D. Volkow, MD, Director of the National Institute on Drug Abuse

I. Introduction
Medication-assisted treatment (MAT) is a treatment method for substance use disorders, including opioid- and alcohol-related issues. MAT combines medication with behavioral therapies or counseling to provide patients with a thorough, comprehensive approach to recovery.

II. Overview of Medication-Assisted Treatment (MAT)
Medication-assisted treatment (MAT) refers to medications used in conjunction with behavioral therapies to treat substance use disorders and prevent overdose. These medications help to rebalance brain chemistry, minimize cravings, block the feeling of euphoria that comes with opioid use, promote long-term recovery, and allow people to function better at home, work, and in the community. MATs are often an essential tool in addiction treatment planning, particularly for opioid use disorder, where they are especially effective.[60]

Despite the efficacy of these medications, maintenance medications continue to carry stigma. Concerns range from potential misuse, a shortage of knowledgeable prescribers, poorly distributed methadone clinics (opioid treatment programs), disdain from some 12-step recovery programs, insurance reticence, and cost. However, research indicates that MATs are highly effective, increase treatment compliance, reduce the risk of relapse, and reduce drug-related mortality.

Many health, medical, and professional organizations have established standards regarding access to MATs. The World Health Organization (WHO), for example, has designated free access to these medications a "best practice," including methadone and buprenorphine for maintenance, naltrexone to prevent relapse, and naloxone for overdose.[61]

60 David A. Fiellin et al., *Opioid Dependence: Rationale for and Efficacy of Existing and New Treatments*, 43 Clinical Infectious Diseases S173, S176 (2006).
61 World Health Org., Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence (2009), https://www.who.int/substance_abuse/publications/opioid_dependence_guidelines.pdf.

There are two main categories of medications for opioid use disorder (MOUD): agonists and antagonists. The first category of MOUD, agonists, activate the same receptors as heroin but are absorbed over an extended period, which staves off withdrawal symptoms. Over time, this disrupts the psychological association between consumption of the drug and feeling high. The second category of MOUD are antagonists. Antagonists do not stimulate drug receptors but rather block the receptor so that if the person taking the drug relapses, they will not experience a high. In the case of buprenorphine, both agonist and antagonist features are present. The receptors are filled to decrease cravings, but the receptors are also blocked so that other opioids cannot get through. Using buprenorphine too soon after an opioid will cause "precipitated withdrawal," leading patients to become very sick. These medications are 40% to 60% effective at promoting abstinence but also serve a role in harm reduction even when abstinence is not achieved.

MAT for alcohol use disorder does not fall into the agonist/antagonist paradigm. Disulfiram (brand name Antabuse) is a deterrent medication that causes illness if you drink alcohol. The other two medications (acamprosate and naltrexone) reduce cravings for alcohol. The efficacy of these medications is less than 20% overall, but they can be very effective for certain individuals.

MAT for tobacco use disorder involves five distinct nicotine replacement products and two medications that decrease cravings for nicotine (bupropion and varenicline, also known as Wellbutrin and Chantix, respectively). These medications are 10% to 30% effective.

Medication-Assisted Treatments

Opioid Use Disorder	Alcohol Use Disorder	Nicotine
Buprenorphine (Subutex, Sublocade, Suboxone, Zubsolv) Activates opioid receptors and blocks euphoria in the event of a relapse.	*Disulfiarm* Produces unpleasant effects in the event of a relapse.	*Nicotine Replacement Therapy*
Methadone (Dolphine, Methadose) Activates opioid receptors.	*Acamprosate* Reduces cravings.	*Varenicline*
Naltrexone (Depade, ReVia, Vivitrol) Blocks euphoria in the event of a relapse and produces unpleasant effects.	*Naltrexone* Reduces cravings.	*Bupropion*

III. Length of Treatment

Individuals who benefit from MATs should continue to use them for as long as they are achieving clinical benefit. There are excellent studies looking at using buprenorphine for time periods

of four weeks, twelve weeks, and six months with an unacceptably high relapse rate. In general, individuals on methadone or buprenorphine should be on it for at least one year.[62] Notably, terminating MAT carries significant risk, including a significant increase in overdose and death.

IV. Misuse of MATs

Misuse of a MAT for an alcohol or tobacco use disorder is very uncommon. However, methadone or buprenorphine for an opioid use disorder can be misused. Misuse is defined as using a medication without a prescription, injecting, snorting, or inhaling one of these medications, using more than prescribed, or selling a portion of a prescription which would lead to a non-therapeutic dose of medication being delivered to a patient. Methadone and buprenorphine are often used as bridge treatment between periods of heroin or fentanyl use and are associated with far lower risks for overdose or death. In some parts of the country, these drugs are made available without a legitimate prescription because the medical system is not meeting the regional need for addiction treatment. Prescribers should be contacted when there is evidence of misuse because a higher level of care or treatment may be needed for these individuals. From a treatment perspective, for those with opioid use disorder, it is better to be on a MAT and periodically relapse or misuse opioids than to not be on the MAT.

V. Use of MATs during pregnancy

Methadone and buprenorphine are safe to use during pregnancy and yield powerful benefits. Studies show that medication access tends to meet barriers including stigma and misconceptions about maintenance therapy. Neonatal abstinence syndrome (NAS) can be expected in about 40% of patients on methadone or buprenorphine. The number is much higher in women exposed to heroin or fentanyl during pregnancy. With continued use of illicit opioids, the fetus and mother are at risk of anoxia (low oxygen), brain damage, overdose death, HIV, Hepatitis B, preterm birth, and Hepatitis C transmission.

Research suggests that children with NAS fare better if the mother is prescribed MAT during pregnancy.[63] Infants born to mothers receiving methadone or buprenorphine are less likely to have a diagnosis of low birth weight and to experience other negative outcomes as compared with newborns of pregnant women who are untreated for opioid dependence.[64] Further, women on methadone or buprenorphine can safely breastfeed, with medical benefits to the newborn.[65] In one research study, newborns exposed to methadone or buprenorphine who were breastfed for at least 30 days had shorter hospital stays and less need for NAS-related medical treatment.[66] Breastfeeding also yields meaningful benefits to attachment. In another important research study, researchers found that parents with opioid dependence who were prescribed naltrexone were more neurologically similar to non-addicted parents than to opioid-addicted parents not receiving treatment.[67]

62 Nat'l Inst. on Drug Abuse, Principles of Drug Addiction Treatment: A Research Based Guide (3rd edition 2018), https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/principles-effective-treatment.

63 Tomas Binder & Blanka Vavrinkova, *Prospective Randomised Comparative Study of the Effect of Buprenorphine, Methadone and Heroin on the Course of Pregnancy, Birthweight of Newborns, Early Postpartum Adaptation and Course of the Neonatal Abstinence Syndrome (NAS) in Women Followed Up in the Outpatient Department*, 29(1) Neuroendocrinology Letters 80 (2008).

64 *Id.*

65 *See* Elisha Wachman et al., *Association of OPRM1 and COMT Single-Nucleotide Polymorphisms with Hospital Length of Stay and Treatment of Neonatal Abstinence Syndrome*, 309 JAMA 1821, 1821-27 (2013), https://www.ncbi.nlm.nih.gov/pubmed/23632726.

66 *Id.*

67 Naltrexone is typically not used during pregnancy unless the patient is already on the medication. In the Wang

Medications for alcohol use disorder and tobacco use disorder are less well studied in pregnancy. In general, the medications for alcohol use disorder are avoided. Nicotine replacement products can be used in pregnancy under the supervision of the woman's prenatal provider. Notably, the harm done by alcohol and tobacco during pregnancy far exceeds the harm of opioids, illicit and prescribed. Fetal alcohol syndrome affects 1% of babies born in the United States and can lead to significant learning and developmental disorders. Tobacco use disorder can cause preterm labor, pre-eclampsia, low birth weight, and other high-risk conditions of pregnancy.

RESOURCES

Food and Drug Administration: www.fda.gov/drugs/information-drug-class/information-about-medication-assisted-treatment-mat

MAT Waiver: www.samhsa.gov/medication-assisted-treatment/training-materials-resources/apply-for-practitioner-waiver

Legal Action Center: Medication-Assisted Treatment in Drug Courts: www.lac.org/wp-content/uploads/2016/04/MATinDrugCourts.pdf

SAMHSA: www.samhsa.gov/medication-assisted-treatment/treatment#medications-used-in-mat

study, the brains of parents on Naltrexone were found to produce far more neural activity in the brain's reward centers when examining pictures of infants than parents who were opioid dependent and not treated with medications. *See* An-Li Wang et al., *Sustained Opioid Antagonism Modulates Striatal Sensitivity to Baby Schema in Patients with Opioid Use Disorder*, 85 J. Substance Abuse Treatment 70 (2018).

Chapter 7: Drug and Alcohol Testing and Monitoring

Steve Paymer, M.S.W., C.P.C.T., President, Paymer Associates, LLC

I. Introduction

It is well known that substance use amongst Americans is of great concern. According to the National Survey on Drug Use and Health (NSDUH), 20.3 million American adults aged 12 years and older battled a Substance Use Disorder (SUD) in 2018.[68] The COVID-19 pandemic has only made matters worse. According to the Centers for Disease Control and Prevention, 13% of Americans reported that they have started, or increased, their substance use as a way of dealing with pandemic-related stress.[69] This chapter focuses on the solution to that problem, namely, how we can use testing and monitoring to assist us in confirming the outcome we are all looking for: healthy, sober, and productive individuals and parents.

The bulk of this chapter will focus on the practical aspects of monitoring, how monitoring can be used as an adjunct to treatment, and how to look at the entire clinical picture when designing an effective monitoring program.

However, it is important to first have a basic understanding of addiction and recovery, and how they relate to testing and monitoring.

Substance use disorder is a chronic illness, a fatal and progressive disease, and should be treated as such. Recovery requires a daily, committed effort. Therefore, even with the most dedicated individuals, a recurrence or relapse is common. In fact, 85% of individuals in treatment will experience relapse within a year, and two out of three individuals will relapse within weeks to months of beginning treatment.[70] As such, sometimes, the best we can hope for is that the monitoring program will act as a tool for harm reduction.

With that said, pain is a great motivator. Over my 20-plus years working in the field of substance use and prevention, I have never met anyone who said to me, "My life is so wonderful, so I am going to stop using drugs and alcohol." Of the thousands of individuals and families I worked with, no one came to me on the wings of victory. In fact, it is just the opposite. Most

68 Substance Use and Mental Health Services Admin., Key Substance Use and Mental Health Indicators in the United States: Results from the 2018 National Survey on Drug Use and Health (2019), https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHNationalFindingsReport2018/NSDUHNationalFindingsReport2018.pdf.

69 Centers for Disease Control and Prevention, Anxiety and Depression: Household Pulse Survey (2020), https://www.cdc.gov/nchs/covid19/pulse/mental-health.htm.

70 Rajita Sinha, *New Findings on Biological Factors Predicting Addiction Relapse Vulnerability*, 13(5) Current Psychiatry Reports 398–405 (2011).

people come to me during one of the worst periods of their lives. Things are falling apart, and they realize that they have to do something to change. The good news is, this is also the time when people are vulnerable and most willing to change. This is a time when people typically will do whatever is requested or suggested by the professionals in the field. What a great opportunity we have to be an effective catalyst towards the goal of improved mental and physical health.

With this in mind, monitoring should never be used as punishment, nor as a panacea for substance misuse. Rather, when used as an adjunct to treatment, monitoring is a very effective tool. In fact, a study of 802 probationers in treatment for substance use conducted in 2011 entitled "The Advantages of Long Term Monitoring" found that those in a treatment program that included monitoring were 55% less likely to be arrested for a new crime, 72% less likely to use drugs, 61% less likely to miss appointments with their supervisory officers, and 53% less likely to have their probation revoked than non-monitored probationers.[71] Additionally, the same study found that 98% of urine tests, 99.6% of remote breath or transdermal alcohol monitoring tests, and 92% of drug sweat patches were negative for drugs and alcohol.

Monitoring is effective because it promotes accountability. To that end, there are usually consequences associated with a failed test. As a result, the fact that a solid monitoring program is in place may be the one thing that keeps an individual from picking up that first drink or drug. This effectively helps buy time until the gains of treatment become internalized. Ideally, when that occurs, the monitoring will no longer be needed. However, in early recovery, substance use monitoring can be an extremely valuable tool until treatment takes hold. That is why I am fond of saying that even if a person fails out of a monitoring program, it has still been useful. It is simply one more data point that the individual can use to see that there is truly a problem.

As a chronic disease, recovery often takes many years and requires the support of numerous providers.[72] Because recovery is so hard, it is vital to try to implement a monitoring program that will not overwhelm the very individual we are trying to assist. With that in mind, it is important to understand that there is no tool on earth, or even combination of tools, that will detect every single ingestion event that takes place. But we must never lose sight of the essence of substance misuse, which is the inability to moderate use. Once an individual with a substance use disorder has ingested that first drink or drug, it is highly likely that they will continue to use. Of course, the individual may get away with it once, or even numerous times, but it will invariably catch up with them. The objective is for us to detect the substance use sooner rather than later.

The remainder of this chapter will focus on the monitoring tools that are available, their practical applications, what they can and cannot do, and how to best utilize them to form a complete monitoring program.

II. General Principles of Testing and Monitoring Programs

Below are some questions and tips that must be considered when developing a testing and monitoring program. These are vitally important, as you want to devise a program that is efficient, cost-effective, and sets the parent up to succeed.

71 Gregory E. Skipper & Robert L. Dupont, *The Advantages of Long-Term Monitoring*, 9(4) Addiction Professional 44–48 (2011).

72 Mike Bury, New Directions in the Sociology of Chronic and Disabling Conditions: Chronic Illness, Self-Management and the Rhetoric of Empowerment 161-179 (In G. Scrambler & S. Scrambler 2010).

- *What are you trying to achieve with the program?* The first step in developing any monitoring program is deciding the objective of the program. Is the goal of the program to show that the parent is completely abstaining from drugs and alcohol at all times, or only when the parent is the custodial parent? Is it intended for the program to act as a harm-reduction tool, e.g., we know that the parent uses recreational marijuana and drinks alcohol, but we want to ensure that no other drugs are being used? Do we want to discover the parent's past drug use or only more recent drug use? These are some of the key questions that need to be answered.

- *How well do you know the parent?* Having as much background information as possible on a parent is important. For example, has the parent ever faced legal consequences with the courts before because of their substance use? Will the parent be able to comply with random urine tests, or will their job interfere with their ability to provide a sample when randomly selected to do so? Does the parent have reliable transportation available needed to get to a collection site? What is the parent's drug of choice? Can the parent afford the cost of the program you are putting in place?

- *Which drugs do you want to detect?* One of the most common mistakes I have seen made is a lack of understanding in regard to which drugs are actually tested for in any given test. For example, when "opiates" are listed as a classification of drug that is included in a drug test, that usually refers to natural opiates: heroin (6-monoacetylmorphine), morphine, and codeine. If you want to test someone for oxycodone, which is a semi-synthetic opioid, you must be sure that it is specified in the drug test panel. Oxycodone will rarely be detected in a drug test that only tests for "opiates." If you do not test for it, it cannot be detected. It is important to note that oftentimes, this is a question of semantics. What one lab calls a 10-Panel test, another lab can call an 11-Panel test. It is important to know what specifically is included in a particular test.

- *What will the consequences be for a failed test?* This is self-explanatory but should be determined at the beginning of the program. Keep in mind that you also want to determine the degree of tolerance for a "missed" test or a failed test that is challenged by other data (as is often the case with alcohol and repeated breath tests). Beyond immediate consequences, what action needs to be taken to resume the regularly scheduled program?

- *Language, language, language.* Nothing can ever be assumed when developing a drug-testing protocol. The initial question to decide is who is responsible for designing the monitoring plan at the outset, and who has the authority to modify the plan over the course of time? Specifically, what testing mechanisms will be used, how frequent will the testing be, and what defines a positive test? Additionally, how long will the monitoring last?

  Further, who receives the results, who is responsible for reporting the results, and to whom do the results get reported? These are just some of the questions that need to be answered and written into the testing protocol. Be as specific as possible. For instance, if you expect a urine test to be done under direct observation, make sure that element is written into the protocol.

- *What do "levels" refer to?* When I am asked to interpret the results of a drug or alcohol test, I am often asked about the significance of the quantitative level of a substance detected in a sample. This is probably the most difficult question to answer. Some will state that levels are irrelevant, that they do not matter at all, and that drug and alcohol testing will simply give us a binary answer – positive or negative. Others will exclaim that levels mean everything and that we can obtain a lot of information from the quantitative level of a positive test. In my view, the answer is probably somewhere in between. The best we can usually do is determine if someone uses a small, medium, or large amount of a certain drug. There is one important exception. Marijuana is one of the very few tested substances that is fat soluble. Marijuana sits in a person's fat stores and leaches its way out of the body. As a result, you cannot take a quantitative level from a positive marijuana drug test and use it to determine the amount that was ingested. Additionally, chronic marijuana users can still test positive in urine tests for many weeks after they have stopped using the substance. Therefore, for marijuana, the best you can do is track any changes in a person's consumption by having the person provide repeated samples over a certain period of time. This will inform on the person's increase, decrease, or apparent consistent use of marijuana.

  The final section of this chapter identifies the tools that are available to use in a monitoring program. Some programs only use one tool, while other programs include all tools at some point in the monitoring. Though the programs differ, they are equally effective because they are designed to meet the unique needs of the client and decisions made by the involved professionals. Thoroughly incorporating the aforementioned principles will help you in deciding which tools will work best.

III. Urine Testing

Urine testing is the oldest and most widely used method of testing for drug and alcohol use. Although the window of detection (e.g., the time in which a drug is detectable) is relatively short, urine testing plays an integral part of any random drug-testing program. The biggest contributions of urine testing are that it is often the least expensive of all drug tests and almost any drug can be detected in urine. Of note, most drugs remain detectable in urine for approximately two to five days. However, as previously mentioned, THC metabolite (marijuana) can be detected in chronic users for extended periods of time after use, anywhere from several weeks to as long as three months.

One of the common misconceptions about urine testing is its susceptibility to manipulation. This may be true in comparison to some other testing methods, but there are ways to increase the difficulty of effectively "cheating" on the test. Currently, there are cutting-edge techniques to ensure that adulteration of urine samples does not occur by conducting thorough screens for adulterants, checking the sample's level of dilution, having a trained individual of the same gender (when specifically requested) observing the donor urinating, and checking the urine sample for proper temperature.

Finally, randomly testing urine, the preferred method when using this mode of testing, is highly effective and difficult to manipulate. It is important that the donor participating in a random urine program remain unaware of the schedule of testing until the morning of the day the test will take place. This dramatically minimizes the chances that the donor can use one of the thou-

sands of products readily available that will defeat the testing process.

IV. Hair Drug Testing

Hair testing is the most effective method of finding regular use of abusive substances. When possible, hair testing is the perfect method to use when starting a monitoring case. Hair testing provides a lengthy window of detection and can be used to establish what drugs have been used regularly, as well as what drugs have not been used regularly. Typically, a one-time drug use, or consumption of a small amount, will not be detected in a hair test.

Procedurally, using a small sample of hair cut at the scalp, hair analysis evaluates the amount of drug metabolites embedded inside the hair shaft. When compared to the more traditional forms of testing such as urine testing, hair samples can detect a longer period of drug use.

With hair samples, the only time limitation for detecting drug usage is imposed by the length of the donor's hair. Each ½ inch of head hair provides a 30-day history of drug use, and the standard for the industry is to test 1.5 inches. This will provide an approximate 90-day history of the donor's drug use. It is important to note that the time frames discussed are approximations. Some individuals have a very steady and fast rate of hair growth, while others may grow head hair slower. The average rate of growth for head hair is ½ inch per 30 days.

If no head hair is available, body hair and fingernails or toenails can be used. However, it is important to note that the window of detection when using body hair or nails is indeterminable due to the high variability of growth rates. That being the case, nails and body hair almost always offer a greater window than head hair and can track consumption patterns up to the previous twelve months. Bleaches, shampoos, and external contaminants (e.g., marijuana smoke) have no known impact on test results.

V. Sweat-Patch Testing

The drug sweat patch is an economical and convenient alternative to urine testing. The patch is worn on the skin for up to 14 days and absorbs sweat, which is then used as the specimen source. After the wear period is over, the old patch is collected and sent to the laboratory for analysis, and a new one is applied. Sweat-patch testing detects both drugs and metabolites. This method allows for full-time coverage (e.g., 24 hours a day, seven days a week). The patch is tamper proof, and the wearer can engage in all activities, including swimming. The patch can be worn on the arm, midriff, or lower back. It is an economical alternative, as it offers far greater coverage than alternative methods such as urine testing, and only requires one trip to the provider every two weeks.

VI. Remote Breath Testing

Over the past 10 years, advances in technology have revolutionized monitoring for alcohol consumption. Remote Breath (RB) Testing devices, such as the SCRAM remote breath testing device and the SL2 device (AKA Soberlink), provide a real-time breath alcohol content (BrAC) and alerts that can be immediately disseminated to concerned parties. These devices, which are used in courts throughout the country, utilize an embedded high-resolution camera to take a still photo of the client as they are blowing into the device. Military grade facial recognition then verifies that the person taking the test is, in fact, the person intended. Although the past use of

alcohol is detectable utilizing urine testing and hair testing, RB Testing dramatically increases the ability to know exactly when a drinking event takes place.

Remote Breath Testing is an extremely valuable tool when developing a protocol for a parent struggling with alcoholism. The most important feature of these devices is that any protocol can be personalized to best meet the needs of the parent, while simultaneously achieving the objective of the monitoring protocol. These devices are small and can be transported easily. Conducting a test takes approximately 60 seconds and can be completed almost anywhere, providing a high degree of privacy.

RB Testing has applications in any case involving alcohol. Of course, RB Testing is used in cases trying to confirm complete abstinence. As previously mentioned, however, remember that no device or tool will capture every small incident of alcohol ingestion. As alcohol is present everywhere, and our cases involve the courts, we must be able to have a very high degree of confidence as to whether a monitored parent truly ingested alcohol or was exposed to incidental or environmental alcohol. As a safeguard, these devices are designed to protect the user from false positives using an automated retesting system. Retesting is standard operating procedure when utilizing breath testing. The objective of the retesting is to establish an elimination rate of the detected alcohol. "Mouth alcohol," such as toothpaste, mouthwash, or cold medicine, to name just a few, will evaporate in a matter of minutes. The average rate of elimination of ingested alcohol, however, can be as rapid as .04 per hour, and as slow as .01 per hour, but is usually around .02 per hour. Simple math will allow you to determine whether an initial positive test was the result of ingested alcohol, or a false positive due to environmental or incidental contact with a product containing alcohol.

One of the best applications of RB Testing is in cases that require the monitored individual to be abstinent only when they are the custodial parent. In these cases, be sure that the testing schedule, or the times in which the person is required to take a breath test, are scheduled at the beginning and at the end of the access period. Tests should also be scheduled throughout access time if that time is greater than five hours. Although we cannot expect someone to test during hours of sleep, and be successful, it is important that there be no more than nine hours between the last test at night, and the first test in the morning, if the custodial period includes an overnight.[73]

VII. Transdermal Alcohol Monitoring

In cases where there is a history of chronic relapse, you may want to consider the use of transdermal alcohol monitoring. This device, commonly referred to as a SCRAM bracelet, measures the insensible perspiration, or sweat in the vapor phase, of the wearer. We all eliminate a small amount of waste products through the skin, and approximately 1% of consumed alcohol is eliminated this way. The bracelet automatically takes a reading of insensible perspiration every half hour and enables a technician to accurately and reliably determine whether a person has consumed a small, moderate, or large amount of alcohol. The resulting transdermal alcohol concentration, or TAC, is semi-quantitative to a blood alcohol concentration. They will be similar to each other at any given time but not exactly the same. Additionally, an infrared sensor contained within the bracelet will detect any attempt to interfere with its ability to detect alcohol.

73 Court-administered Secure Continuous Remote Alcohol Monitoring (SCRAM) can be useful. However, in Massachusetts probation only receives alerts of a failed or missed test during hours of court operation. As a result, evenings, overnights, and weekends do not have real-time monitoring, which can be problematic.

Although intimidating at first, the bracelet can be a very valuable tool when developing a protocol. It is best used to establish abstinence from alcohol for those who have not been successful in other monitoring programs. Most people report that after a day or two, it is no longer uncomfortable to wear, and they appreciate the fact that they do not have to stop what they are doing to conduct a test.

When considering this technology, bear in mind that it does not provide real-time results. Samples are taken every 30 minutes and stored in the bracelet's internal memory. At a designated time, usually when the client is asleep, those readings are remotely sent to a base station inside the client's home. The base station then sends the data to technicians, who interpret it. Should a confirmed drinking event or tamper event occur, notifications are sent the next morning.

VIII. Conclusion

Preparing a solid drug-testing protocol takes experience, knowledge of the technology, nuance, and a basic understanding of substance use. It is my sincere hope that the information contained in this chapter will assist you in developing a protocol that assists the client in maintaining abstinence, and promoting a quality of life that is happy, joyous, and free from the debilitating consequences of SUD. Never hesitate to reach out and ask a professional in this field a question if you are unsure of anything. The consequences of failure in these programs can affect a parent's livelihood and their ability to have a relationship with their children. It is vitally important that your protocol be based on science and applied in such a manner that it adds to the parent's overall recovery program.

RESOURCES

Department of Health and Human Services:

Specimen Collection Handbook: www.samhsa.gov/sites/default/files/workplace/urine-specimen-collection-handbook-oct2017_2.pdf

SAMHSA: Clinical Drug Testing in Primary Care: www.store.samhsa.gov/system/files/sma12-4668.pdf

U.S. National Library of Medicine: www.medlineplus.gov/lab-tests/drug-testing

Chapter 8: Substance Use and Commercial Sexual Exploitation in Family Court

Abigail M. Judge, Ph.D., Massachusetts General Hospital, Harvard Medical School, Boston, MA

Nikki Bell, Living in Freedom Together (LIFT), Worcester, MA

I. Introduction

Commercial sexual exploitation and substance use are highly related problems for many women seen in family court. However, the connections between these topics are poorly understood and frequently overlooked. Commercial sexual exploitation (CSE) refers to the entire continuum of sex trading, prostitution, and sex trafficking. Many sexually exploited women also struggle with substance use, and many of these women are mothers. These associations create several possible intersections with family court jurisdiction: custody disputes, guardianship, parenting evaluations, and child protection matters.

Despite these links, there is limited awareness and literature about the unique needs of women affected by substance use and commercial sexual exploitation in family court. This is a missed opportunity, since the recognition of CSE in family court can be essential to developing a theory of the case, refining an attorney's legal advocacy, and most importantly, helping link women to appropriate services.[74]

In this chapter, we provide definitions and an overview of commercial sexual exploitation and then describe how CSE and SUD are often intertwined. We use our professional experience, coupled with the limited available research, to present eight practice tips for the Massachusetts judiciary for addressing the role of commercial sexual exploitation among women with substance use who present to family court. This includes a more comprehensive understanding of commercial sexual exploitation, its intersections with substance use, the influential role of stigma for affected women, and practice recommendations.

II. What is Commercial Sexual Exploitation (CSE)?

Collectively, commercial sexual exploitation refers to the continuum of sex trading, prostitution, and sex trafficking. Trading sex for basic needs is often referred to as survival sex, in which a person engages because of their extreme need. Survival sex "describes the practice of people

74 Lawyer's Manual on Human Trafficking: Pursuing Justice for Victims, 193-203 (J.L. Goodman & D.A. Leidholdt eds., 2011), http://ww2.nycourts.gov/sites/default/files/document/files/2018-07/LMHT_0.pdf.

who are homeless or otherwise disadvantaged in society, trading sex for food, a place to sleep, or other basic needs, or for drugs. The term is used by sex trade, poverty researchers, and aid workers."[75]

There is confusion and controversy within academic and advocacy communities about the relationships among commercial sexual exploitation, prostitution, sex trading, and sex trafficking involving adults. Research, and the broader culture, tend to examine the problems of sex trafficking and others forms of the sex trade in isolation. This has resulted in a "divided framework" in understanding empirical evidence as it relates to women in prostitution and sexually trafficked and exploited women and girls.[76]

The crux of the controversy involves the role of force, fraud, or coercion, which are the legal elements required in order for commercial sex involving adults to be defined as a crime of sex trafficking. The federal definition of sex trafficking includes "the recruitment, harboring, transportation, provision, or obtaining of a person for the purpose of a commercial sex act."[77] For adults, sex trafficking occurs when an adult is induced by force, fraud, or coercion to perform a sex act for money or anything of financial value. Different statutes apply for minors, with any commercial sex act involving a person under age 18 defined as sex trafficking. Unlike federal law, Massachusetts does not require evidence that a trafficker used "force, fraud or coercion" to bring someone into the commercial sex trade.[78]

These distinctions matter because law and policy can create problematic differences between "free" and "forced" victims, which can affect how women understand their own situation, how systems frame their needs, and what services they can access. In recent years, for example, the healthcare sector has emphasized research and services for sex trafficking, which has unwittingly fostered distinctions between trafficking victims who are "forced" (and therefore sympathetic) versus those who freely "chose" prostitution (and are therefore culpable).[79]

Women who are trafficked for sex and women involved in prostitution both engage in the sale of sex for money. However, women who are trafficked for sex are more likely to be classified as victims, and women who engage in prostitution are classified as offenders, based largely on the belief that trafficked women are coerced into the sale of sex and prostituted women are not. In reality, the majority of prostituted adults were initially sexually exploited as adolescents. No matter a person's age when entering the sex trade, this typically happens due to dire circumstances such as lack of income/poverty, educational inequalities, homelessness, etc.

All forms of the sex trade are associated with high rates of physical and sexual violence. "Given the pervasiveness of maltreatment and coercion, it becomes less justifiable to claim that 'choice' and/or 'willingness' are meaningful criteria by which to make a distinction between being trafficked and prostituted."[80] Although beyond the scope of this chapter, it is critical to note that all forms of CSE exist due to a social demand for commercial sex. The commercial demand for

75 R. Barri Flowers, Street Kids: The Livesof Runaway and Thrownaway Teens 110-11 (2010).
76 Lara Gerassi, *A Heated Debate: Theoretical Perspectives of Sexual Exploitation and Sex Work*, 42 J. Soc. Soc. Welfare 79-100 (2015).
77 22 U.S.C. § 7102.
78 G. L. c. 65 §50.
79 Mary A. Finn et al., *Exploring the Overlap Between Victimization and Offending Among Women in Sex Work*, 10 Victims & Offenders 74 (2014).
80 Bincy Wilson & Lisa D. Butler, *Running a Gauntlet: A Review of Victimization and Violence in the Pre-entry, Post-entry, and Peri-/Post-exit Periods of Commercial Sexual Exploitation*, 6 Psych. Trauma: Theory, Rsch., Practice, and Pol'y 494-95 (2014), https://psycnet.apa.org/doiLanding?doi=10.1037%2Fa0032977.

prostitution fuels demand for sex trafficking, and vice versa.

The role of "force" in CSE can mean physical force via abduction or violence, but also the constrained choices that result from the intersecting systems of social oppression. The survivor, activist, and author Rachel Moran wrote about her own entry into prostitution at the age of 16 when she became homeless after her father committed suicide and her mother was unable to take care of her due to untreated schizophrenia. As Moran explained,

> It is a very human foolishness to insist on the presence of a knife or a gun or a fist in order to recognize the existence of force, when often the most compelling forces on this earth present intangibly, in coercive situations. My prostitution experience was coerced. For those of us who fall into the 'free' category, it is life that does the coercing. People concentrate so much on the differences between prostituted women and trafficking victims that they forget there are far more similarities than differences.[81]

Consistent with this survivor-centered view, CSE includes situations that are exploitative but may not meet the legal definition of trafficking. This includes the following examples of sexual exploitation[82]:

- A woman who is homeless and engages in survival sex: she exchanges sex for money, food, and a place to stay
- A woman who is coerced into having sex with a police officer in order to avoid arrest
- A woman with an opioid use disorder who has sex with her dealer when she doesn't have any money and is in withdrawal

We recommend that family court practitioners embrace this more complex understanding of "choice" when interacting with sexually exploited women in order to avoid an unintentionally harmful distinction between "forced" and "free" victims. There is limited acknowledgement in the judicial system that prostituted women are often victims of exploitation in the first place.[83] This contributes to stigma, depression, demoralization, and limited vocational opportunities for women trying to exit CSE. Each of these factors increase women's vulnerability to re-involvement in the sex trade.

III. Who is Affected by Commercial Sexual Exploitation?

Although theoretically anyone can be sexually exploited, the risk is not evenly distributed in our communities. Individuals who are socially oppressed and marginalized are disproportionately vulnerable to involvement in the commercial sex trade. This includes girls and women, those experiencing past or current poverty and/or lack of educational and vocational opportunities, those experiencing discrimination due to race, ethnicity, gender or sexual orientation, and those with histories of abuse and violence. Among studies of female adolescents in child welfare or juvenile justice care, CSE rates range from 54% to 62%.[84]

Housing instability and homelessness are also associated with CSE among young adults and

81 Rachel Moran, Paid For: My Journey through Prostitution 227 (2015)
82 Nicole Bell et al., Addressing a By-Product of the Opioid Addiction Crisis: Commercial Sexual Exploitation (2018), https://escholarship.umassmed.edu/ner/55.
83 Corey Shdaimah & Shelly Wiechelt, *Crime and Compassion: Women in Prostitution at the Intersection of Criminality and Victimization*, 19 Int'l Rev. Victimology 23–35 (2012).
84 Joan A. Reid, System Failure! Is the Department of Children and Families (DCF) Facilitating Sex Trafficking of Foster Girls? in Social Work Practice with Survivors of Sex Trafficking and Commercial Sexual Exploitation 298–315 (A. G. Nichols, T. Edmond, & E. C. Heil Eds., 2018).

adult women. In a multi-country study of prostituted women, 75% of women across nine countries and 84% of the U.S. sample had been homeless at one point in their lives.[85] The need for shelter or residential living facilities is one of most commonly reported needs of sexually exploited women.

These data show the ways in which victimization in the sex trade is deeply tied to intersecting systems of social oppression that marginalize vulnerable groups and create vulnerability to CSE. "While the primary means of exploitation by international sex traffickers is manufacturing vulnerability in their victims by tearing them away from their community, domestic sex traffickers *typically depend on identifying, exacerbating, and exploiting existing vulnerabilities in their victims*."[86] One such vulnerability is the presence of substance use or dependency.

IV. Commercial Sexual Exploitation and Substance Use

Research demonstrates a strong association between substance use and CSE. More than fifty percent of women who present to substance use treatment report a lifetime history of sex trading or prostitution as a part of their addiction.[87] Substance use in this population almost universally follows trauma. There are several ways that CSE and SUD may be associated.

Substance use can exist prior to exploitation and prostitution and be a risk factor for being exploited in the first place. Substance dependency makes individuals vulnerable to engaging in sexual acts in exchange for substances, which increases the risk for prostitution and trafficking. Exploiters also deliberately target locations where women in active addiction seek care (e.g., detox, methadone clinics, etc.) to develop relationships with potential victims.

In other situations, substance use results from forced dependence by a third-party exploiter, pimp, or trafficker. An exploiter or pimp who provides and then withholds substances from a person is a highly effective, albeit cruel, form of control and coercion. Substance use during and after exploitation is also a means of coping with surviving the physical and sexual violence of the sex trade through numbing.

Regardless of whether substance use or exploitation comes first, once they both exist the two problems can be mutually reinforcing: substance use increases vulnerability to sexual exploitation, which in turn worsens symptoms of post-traumatic stress and increases SUD.[88] Such a "vicious cycle" highlights the mutual reinforcement of SUD and CSE and the need for treatment to address both problems in an integrated manner. Effective treatment for substance use among victims and survivors of CSE is a primary and often unmet need.

In fact, there is only one specialized, integrated residential program in Massachusetts specifically designed to address SUD and CSE.[89] In Massachusetts there are more male than female SUD

85 Melissa Farley et al., *Prostitution in Nine Countries: An Update on Violence and Posttraumatic Stress Disorder*, 2 J. Trauma Prac. 33 (2003).
86 Stephen Parker & Jonathan Skrmetti, *Pimps Down: A Prosecutorial Perspective on Domestic Sex Trafficking*, 43 Univ. Memphis L. Rev. 1013-45 (2013) (emphasis added).
87 Mandi L. Burnette et al., *Prevalence and Health Correlates of Prostitution Among Patients Entering Treatment for Substance Use Disorders*, 65 Archives of Gen. Psychiatry 337 (2008).
88 Maureen A. Norton-Hawk, *The Counterproductivity of Incarcerating Female Street Prostitutes*, 22 Deviant Behavior 403 (2011).
89 Living in Freedom Together (LIFT) of Worcester, MA opened Jana's Place in 2019, the first residential treatment program in the country for survivors of commercial sexual exploitation with SUD. Author NB founded and is the CEO of LIFT.

treatment beds available. In addition to a lack of specialized care for this population, there are particular safety concerns when women involved in CSE relapse or leave against medical advice while in residential or sober living. If women are discharged from care without safety planning or stable housing, they are at high risk not only for opioid overdose but also violence, injury, and homicide by sex buyers.

V. Parenting, Commercial Sexual Exploitation, and Substance Use

There are high rates of pregnancy and live births among women in the sex trade, but in general, very little is known about the unique needs of prostituted, sex trading, or trafficked women as parents or the challenges they face as pregnant/parenting women.[90] Since many women are recruited into CSE by a boyfriend, husband, or partner who acts as a pimp, the child's father may be the same individual who exploited the woman. In other instances, a situation of exploitation or trafficking can shift into a familial structure where a caring relationship may exist between the children and the father. Unfortunately, the mother's past history of abuse and exploitation by her partner/pimp may not be readily apparent to the Court. It is therefore important for attorneys and other family court practitioners to consider this possibility and the implications for co-parenting in any given case.

A study of women in the criminal justice system compared mothers with and without a history of prostitution and found a history of prostitution to be associated with more exposure to violence, living in areas with high drug activity, and higher rates of physical and mental health concerns.[91] Almost all women in this study reported a desire to stop sex trading/prostitution and to find alternative employment, which is consistent with past research.

In addition, women in street-level prostitution report feeling stigmatized due to engaging in prostitution as mothers and express fear of accessing services in case they are deemed unfit as parents and separated from their children. Shame about a history of being prostituted can lead victims to withhold information in mental health or forensic evaluations in the context of family court. This could greatly undermine the utility of such an evaluation by preventing women from accessing legal protection and services, which, in turn, may increase risk of re-victimization or parenting problems. In light of this stigma and shame, forensic evaluators should have specialized training in the dynamics of CSE, and attorneys must prepare clients with histories of CSE for forensic evaluations.

Despite the multiple challenges associated with parenting and SUD, sexually exploited women with SUD may be highly dedicated to caring for their children and may see pregnancy/parenting as a strong motivator to manage their addictions. When motivation for change is high, SUD treatment is more likely to be effective. Thus, harnessing women's motivation to fulfill a parenting role can be a powerful tool for engagement in recovery and treatment. Women need comprehensive and tailored supports to do so. Effective intervention must also address the role of guilt and shame among mothers with SUD, which can interfere with a parent's ability to be emotionally available and empathetic with her children. Survivors of CSE may experience an even greater burden of shame and marginalization due to prostitution stigma and feared judgment

90 Putu Duff et al., *High Lifetime Pregnancy and Low Contraceptive Usage Among Sex Workers Who Use Drugs—an Unmet Reproductive Health Need*, 11 BMC Pregnancy and Childbirth (2011), https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/1471-2393-11-61.

91 Tasha R. Perdue et al., *Offenders Who Are Mothers with and without Experience in Prostitution: Differences in Historical Trauma, Current Stressors, and Physical and Mental Health Differences*, 22 Women's Health Issues (2012).

by individuals in authority and social systems. Trauma-informed care that strives to reduce the re-traumatization that results from interventions that induce shame and guilt is essential for this population.

VI. Implications for Family Court: 8 Practical Tips

1. *Court professionals should be aware that sexually exploited individuals may present themselves as litigants in a variety of cases appearing before the court. Awareness will assist court practitioners in linking women and families with assistance.*
    - This includes child abuse and neglect, foster/out-of-home placement, adolescent truancy and running away, guardianship and custody disputes, to name a few.
    - Sexually exploited women may present to court, even if the impact of CSE is never dis closed.
2. *When SUD is part of a litigant's life, consider the possible role of commercial sexual exploitation.*
    - Given the strong relationship between CSE and SUD, consider what impact commercial sexual exploitation has on the case before you.
    - Remember that the process of exploitation, and the associated shame and stigma, prevent women from disclosing their experiences, particularly in as intimidating and high stakes a setting as court.
3. *Use a trauma-informed lens to understand women's behavior in court. Challenge your assumptions about how a victim of CSE "should" behave.*
    - Courts are very stressful places, and this is often reflected in courtroom behavior.
    - A core principle of trauma-informed care is the recognition that a survivor's behavior reflects an adaptation totrauma.
        - Most survivors have had negative experiences with formal systems prior to and while being exploited (e.g., child protection, health care, law enforcement). This includes harm while in institutional care and solicitation or violence by the police.
    - Given the high-stakes and adversarial nature of the court setting, litigants involved in CSE may feel even more hyper-vigilant and anxious in this setting. This can manifest in "difficult" behaviors (e.g., mistrust, evasiveness, anger) that are actually signs of traumatic stress. As researchers have cautioned: "Our legal responses oftentimes require that victims behave passively and/or actively cooperate with law enforcement…in order to be regarded as blameless and deserving of assistance."[92]
    - Some litigants may seem "passive and cooperative," while others may not. There is no "right way" for a traumatized person to behave. Do not make assumptions about how a litigant who has been sexually exploited should act. Use a trauma-informed lens to put confusing behavior in context.
4. *Identifying as a victim of CSE or person in need of help is a process.*
    - Do not expect all victims to recognize their situation as exploitive, or to present as a victim in need of immediate service or intervention. Self-identifying as a victim varies depending on the relationship with one's exploiter (e.g., intimate partner, family member), whether court involvement was sought or involuntary, and also the availability of options to support her exit. How women understand the role of CSE in their life is also likely to change over the course of recovery.
    - Given these dynamics, interventions should focus on engaging women in the

92 Mary A. Finn et al., *Exploring the Overlap Between Victimization and Offending Among Women in Sex Work*, 10 Victims & Offenders 74 (2014).

services they desire, not "rescue."
    - Link survivors to resources that can support women across the long, non-linear process of recovery.
    - Services should address the factors that make women vulnerable to ongoing involvement in the sex trade: substance use, housing instability or homelessness, lack of vocational alternatives, untreated mental health concerns, etc.
- Survivors are a diverse group with different needs and varying patterns of exit. Interventions are most effective when tailored to these differences.

5. *Medication for opioid use disorder (MOUD), or medication-assisted therapy (MAT) is an evidence-based treatment for opioid use disorder that should not be stigmatized in family court.*
    - Appropriate engagement in MOUD is often a critical component of effective treatment for opioid use disorder.
    - MOUD / MAT is endorsed as a "best practice" by the World Health Organization (WHO) and the National Association of Drug Court Professionals (NADCP), but some family drug courts prohibit participants from using it.[93]
    - Sexually exploited women endure multiple forms of discrimination, and their appropriate engagement in MOUD is a strength and form of help-seeking. It should not be an additional source of stigma.
6. *Intimate partner violence provides a starting point for courts to understand CSE.*
    - Intimate partner violence (IPV) is currently better understood in family court, and there are similarities between IPV and CSE:
        - The complex relationship between exploiter and victim
        - The secrecy of the crime
        - Heightened safety concerns / potential lethality of exploiters and sex buyers
        - Reluctance to identify as a victim
        - Multiple attempts needed to exit
    - Consider the possible role of coercion and control on women's behavior and engagement in Court proceedings. Like perpetrators of IPV, many exploiters / pimps are also family members, boyfriends, and partners.
    - Exploiters often use pregnancy and children as a form of control and will attack women's credibility due to past prostitution arrests. Consider these possibilities during child custody and guardianship proceedings.
7. *Are supports and treatment being offered appropriate for women affected by these issues?*
    - SUD is a chronic disease associated with brain changes. Similarly, the process of exiting and recovery from CSE also takes time.
    - Recovery from both SUD and CSE is non-linear and requires services tailored to these dynamics. When someone is "failing" in treatment, consider whether the care being offered is appropriate to their situation. A "failure to engage" in treatment can sometimes indicate that services being offered are not sufficient. Some questions to consider include:
        - Is the treatment offered trauma-informed and integrated (e.g., treating SUD and the effects of trauma)?
        - Are the mental health professionals involved familiar with commercial sexual exploitation? This is an area of specialized competence and is not something

93 Stephanie Tabashneck, *Family Drug Courts: Combatting the Opioid Epidemic*, 52 Family Law Quarterly 183 (2018).

that all therapists understand.
    - Is the litigant connected to survivor-led programming, and if not, can a referral be made?
    - Would a program where mother and children reside together be a better fit?
- Many survivors have a hard time finding places where exploitation can be addressed safely and without additional stigma or re-victimization.
    - This includes, for example, re-victimization in 12-step communities, provider voyeurism about the sex trade, and limited gender-specific programming. These factors can affect a women's participation in care and peer-support groups.
    - If a woman's involvement in peer support is mandated and she is not attending regularly, consider whether these particular barriers are getting in the way.
- If a residential program is involved, consider what safety planning is offered in case a woman leaves against medical advice due to traumatic stress symptoms or addiction. Without such planning, women are at very high risk for overdose, re-exploitation, violence, and homicide.

8. Survivors have complex service needs that no one professional or agency can provide on its own.
    - Survivors of CSE are poorly served by traditional social services. In response, survivor professional-led programs have developed sophisticated models of peer support and advocacy to help women exit and recover.
        - Court practitioners should build relationships with agencies led by survivor professionals that provide education, direct services, and advocacy. Court practitioners should also partner with such organizations before designing court-based services for survivors.
    - If a forensic evaluation is ordered for litigants with a history of CSE, make sure the evaluator has expertise in this topic.
    - When mental health treatment and addiction treatment are required, refer women to professionals with specialized competence in CSE and SUD. All therapy is not the same, and expertise really matters for this population.
    - Women affected by CSE require a network of flexible, long-term support that combines survivor-led and psychiatric/addiction expertise. Although it is time consuming to build the right network, supports that are tailored to the needs of women exiting CSE can make all the difference.

RESOURCES

Living in Freedom Together (LIFT), Worcester, MA: http://www.liftworcester.org/

MGH Substance Use Disorders Bridge Clinic, Boston, MA: www.massgeneral.org/substance-use-disorders-initiative; 617-643-8281

My Life My Choice, Boston, MA: www.mylifemychoice.org

National Human Trafficking Hotline: www.humantraffickinghotline.org; 1-888-373-7888

Polaris: www.polarisproject.org/human-trafficking/recognize-signs

Project ASSERT, Boston Medical Center, Boston, MA: www.bmc.org/programs/project-assert

Chapter 9: Guardianships of Minor Children: The Legal Process

Alicia Doherty, Esq., Assistant Judicial Case Manager of the Probate and Family Court, Worcester Division

I. Introduction

In the United States, over 2.6 million children are being raised by someone other than a parent. A grandparent, relative, or family friend often assumes this role.[94] Over 30,000 grandparents in Massachusetts are caring for and raising their grandchildren, with approximately one-third of these families having no parental involvement at all.[95] In many cases, grandparents or other relatives begin by caring for these minor children as a way to support their adult-child or relative. While some cases are temporary due to a short-term medical condition, such as a surgery, or a transition within a family, such as a relocation to another state during the school year, a significant number of guardianship cases of minor children are the result of the opioid crisis and substance use disorders (SUDs).[96]

Many caregivers hope that the reduced responsibility of parenting will allow the parent an opportunity to regain their sobriety or receive needed mental health treatment. Initially, parents in these situations are often receptive to accepting help. Parents may voluntarily allow the child to live with the grandparent or relative caregiver, or even give written authority to maintain the assistance. However, in many cases involving a parent's SUDs or untreated mental health issues, recovery often requires multiple support services and long-term treatment. To ensure the care and protection of minor children, legal guardianship is often sought through the courts.

II.Alternatives to Guardianship

In Massachusetts, a parent or guardian may execute a Caregiver Affidavit, which grants another adult (18 years or older) the right to make medical and educational decisions for his or her minor child.[97] While this form authorizes caregivers to obtain routine medical treatment for the child, or to communicate with schools, it is often unacceptable as a long-term solution. The authority granted in the Caregiver Affidavit is for a period of up to two years and can be revoked by the parent at any time. The revocation is effective simply by the parent writing a statement to the designated caregiver.

94 National Community Reinvestment Coalition, *Resources for Grandparents Raising Grandchildren* (April 19, 2019), https://www.ncrc.org/resources-for-grandparents-raising-grandchildren.

95 Granparents or Relative Caregivers Raising Children in Massachusetts Due to Parental Opioid Use, Report of Study Results 7 (2019), http://massgrg.com/massgrg_2019/assets/files/UMass-Report-Grandparents-Raising-Grandchildren-Updated-09062019.pdf.

96 Suzanne C. Brundage & Carol Levine, *The Ripple Effect: The Impact of the Opioid Epidemic on Children and Families*, 17 (2019), https://uhfnyc.org/media/filer_public/17/2c/172ca968-43aa-45f9-a290-50018e85a9d8/uhf-opioids-20190315.pdf.

97 G. L. c. 201F, §§1-6.

This uncertainty presents significant challenges to child welfare agencies, physicians' offices, and schools, all of which rely on the caregiver's authority. Those most often concerned by this revocable power are the individual caretakers themselves, as they have witnessed a history of the parent's unpredictable behavior. In some cases, the parent who grants this authority may be actively misusing drugs or alcohol or suffering from untreated mental health issues. Not only can the parent rescind the decision-making authority of the named caregiver, he or she has the ability to override the caretaker's decision if a conflict arises. For these reasons, a Caregiver Affidavit is a guardianship alternative that is best suited for its original intent, where the physical safety and well-being of the child is not a concern. Rather, in these cases, the role of the designated caregiver would be to provide parental support or caregiving responsibilities during a time of transition within a family, while maintaining structure, security, and consistency for the minor child.

III. The Department of Children and Families

The state's child welfare agency, known in Massachusetts as the Department of Children and Families (DCF), is responsible for screening complaints of alleged abuse or neglect.[98] Complaints are frequently made to DCF by a mandated reporter, such as a teacher or counselor in the child's school or a police officer who responds to a call involving one or both parents and a child is present. These complaints often stem from domestic violence, substance use disorders, or the mental health of a parent.[99] DCF may also be involved with a family if a parent voluntarily applies and is approved for services.[100] After assessing a claim of abuse or neglect, DCF makes a determination of whether or not to support and further investigate the allegation(s).[101]

In some situations, DCF will not pursue custody of the child or seek to have the child removed from the home but will continue to work with the parents or guardians by providing regular support services and case management. Where there are more serious allegations, however, such as an immediate concern for the safety of a child or a lack of appropriate placement, DCF may remove the child and pursue legal custody by filing a Care and Protection Petition in the Juvenile Court.[102] In some cases, DCF will retain custody but seek to place the child with a family member through a kinship placement or a guardianship in the Juvenile Court. For Care and Protection cases in the Juvenile Court, both parents, as well as the minor child, are appointed an attorney by the Court to represent them.[103]

Commonly, if there is a suitable family member or third party who has already been caring for the child, the DCF social worker will work with the family to have the caretaker file a guardianship petition with the Probate and Family Court. Once a legal guardian is appointed by the

98 Barbara Kaban & Virginia G. Weisz, Protecting Children: A Study of the Nature and Management of Guardianship of Minor Cases in the Probate and Family Court 35 (2008), www.clcm.org/Guardianship_Report-8-06-08.pdf; Pursuant to G. L. c. 119, §51A.
99 Suzanne C. Brundage & Carol Levine, *The Ripple Effect: The Impact of the Opioid Epidemic on Children and Families*, 17 (2019), https://uhfnyc.org/media/filer_public/17/2c/172ca968-43aa-45f9-a290-50018e85a9d8/uhf-opioids-20190315.pdf.
100 110 CMR 4.01(2); 110 CMR 4.70.
101 110 CMR 4.32.
102 110 CMR 4.29.
103 *See* Rule 4 of the Massachusetts Juvenile Court, https://www.mass.gov/juvenile-court-rules/rules-for-the-care-and-protection-of-children-rule-4-appointment-of-counsel ("Counsel to be appointed pursuant to G.L. c. 119, §29 and c. 211D. The Massachusetts Rules of the Supreme Judicial Court, Rule 3:10, and applicable case law.")

Court, and there is no longer a concern for the safety of the child, DCF may close the case.[104]

IV. Guardianships of Minors in the Massachusetts Probate and Family Court

Petitions for Guardianship of a Minor Child are often filed on an ex-parte basis without notice to one or both parents. Petitioners are usually the caretakers of the child and frequently seek an immediate or expedited hearing for a Temporary Guardianship. Many Petitioners have limited information of where either parent is living, as communications between the parents and the Petitioners have often broken down, due to the parents' SUD, erratic behavior, or homelessness. As a result, proper service may be difficult to effectuate but is required even if it is completed and filed after the initial hearing.

Commonly, Petitioners file incomplete or inaccurate pleadings, especially if there is an unknown or uninvolved father or if the parent's whereabouts is unknown. Many are unable to determine the adjudication or paternity of the child, based on the child's birth certificate. In Massachusetts, copies of birth certificates for a person born out of wedlock are restricted by the Registry of Vital Records and Statistics to certain individuals, without a Court Order.[105] Those factors present issues in determining paternity, proper service, and legal standing for a putative father. Once appointed, a Guardian, through a Court Order, is entitled to obtain a certified copy of the minor child's birth certificate.[106]

In the initial proceedings, the Petitioner is often self-represented, or pro se. They are often unfamiliar with the process, and fear that if an emergency Temporary Order is not granted, they will lose the minor child either to the state's custody or to the parent. If an emergency hearing is held on an ex-parte basis, the courts must weigh the parent's legal right to notice of the proceeding[107] against the emergency circumstances alleged by the Petitioner and the potential need to secure the safety and well-being of the child.

Depending on the circumstances presented at an emergency hearing, either a Temporary Order based on a Motion for an immediate appointment with a supporting Affidavit or a Short Order of Notice may be granted.[108] If an expedited hearing is scheduled, an Order will be issued for

104 110 CMR 9.02(2).
105 G. L. c. 46, §2A.
106 *Id.*
107 *L.B. and another v. Chief Justice of the Probate and Family Court*, 474 Mass. 234, 237 (2016) ("It is well settled that "parents have a fundamental liberty interest in the care, custody, and management of their children," *Matter of Hilary*, 450 Mass. 491, 496 (2008), and that "[d]ue process requirements must be met where a parent is deprived of the right to raise his or her child." *Care & Protection of Erin*, 443 Mass. 567, 571 (2005). *See Department of Pub. Welfare v. J.K.B.*, 379 Mass. 1, 3 (1979). "In determining what process is due . . . this court 'must balance the interests of the individual affected, the risk of erroneous deprivation of those interests and the government's interest in the efficient and economic administration of its affairs.'" *Commonwealth v. Barboza*, 387 Mass. 105, 112, cert. denied, 459 U.S. 1020 (1982), quoting *Thompson v. Commonwealth*, 386 Mass. 811, 817 (1982). *See Care & Protection of Robert*, 408 Mass. 52, 58-59 (1990). When balancing the interests, we bear in mind that "[t]he requirements of procedural due process are pragmatic and flexible, not rigid or hypertechnical." *Roe v. Attorney Gen.*, 434 Mass. 418, 427 (2001). Due process "calls for such procedural protections as the particular situation demands." *Id.*, quoting *Morrissey v. Brewer*, 408 U.S. 471, 481 (1972).").
108 *See* G. L. c. 190B, §5-204(e) ("If the court determines that an immediate emergency situation exists which requires the immediate appointment of a temporary guardian, it may shorten or waive the notice requirements in whole or in part and grant the motion, provided, however, that prior notice shall be given to the minor, if the minor is 14 or more years of age, as the court may order and post-appointment notice of any appointment is given to the minor and those named in the petition for appointment of guardian stating further that any such person may move to vacate the order of the court or request that the court take any other appropriate action on the matter, and on

immediate notice to all interested parties. Petitioners are also required to provide proper notice of the underlying Petition for Guardianship to all interested parties, including the minor child, if 14 years or older.[109] In cases with urgent circumstances, a Verified Motion for Temporary Guardianship must be filed with the underlying petition. If DCF is involved with the family, the judge in the Probate and Family Court may issue an Order to Disclose for the DCF social worker to testify at the initial hearing. Alternatively, the Court may refer the Probation Department to contact DCF and obtain written information regarding DCF's involvement with the child and family, and any circumstances that may warrant the Court to issue a Temporary Order on an emergency basis.[110]

For the safety of the child, criminal background checks are conducted by the Probation Department on the Petitioner and all involved parties prior to a Petitioner's appointment as temporary or permanent guardian. In addition to proper notice to all interested parties, Petitioners seeking special authority such as the Court's permission to remove the child to reside outside of the Commonwealth of Massachusetts must receive Court approval, even at the Temporary Order stage of the proceedings.

Parents in Guardianship of Minor Petitions have the right to be represented by legal counsel if they so choose. Indigent parents are entitled to apply for the appointment of legal counsel through the Court.[111] A minor child, who is the subject of the Petition for Guardianship, shall be appointed counsel by the court, upon his or her request (if 14 years or older), or by someone else, filing a request on the child's behalf.[112] During these proceedings, a parent may file a written, Notarized Consent to the guardianship petition, or a Notice of Appearance and Objection and supporting Affidavit of Objection, to the temporary or permanent appointment of a guardian.

V. Temporary v. Permanent Guardianship

Upon the expiration date of an Order for a Temporary Guardian, if good cause has been shown to the Court, it is within the Court's discretion to extend a Temporary Order for a period of 90 days.[113] Generally, the purpose of an extension is to allow for proper service, if one or both parents are unable to be served. Further, it provides parent(s) with an opportunity to work with the Temporary Guardian or DCF, if involved, and engage in support services. Services may include counseling for mental health or domestic violence, participation in substance use disorder treatment programs, or assistance with applying for employment or housing. In cases involving allegations of substance use disorder, the Court may order the parent to submit to random drug screenings through the Court's Probation Department, as a safeguard for allowing parenting time and contact with the child.

Guardianship petitions that have the written, notarized assents from both parents and the minor (if 14 years or older), may be allowed at the first hearing and a permanent decree entered. Other

said motion to vacate. The court shall hear said motion as a de novo matter, as expeditiously as possible. A certificate stating that such notice has been given shall be filed with the court within 7 days following the appointment. Upon failure to file such certificate the court may on its own motion vacate said order.").

109 Massachusetts Probate and Family Court, Standing Order 4-09: Notice in Guardianship of Minors Matters (2010); G. L. c. 109B, §1-401(b).

110 Massachusetts Probate and Family Court Standing Order 2-11: Probate and Family Court's Use of Information Obtained by the Department of Children and Families (2011); G. L. c. §§51E, 51F.

111 *Guardianship of V.V.*, 470 Mass. 590 (2015).

112 G. L. c. 190B, §5-106.

113 G. L. c. 190B, §5-204(b).

petitions may take up to a year, through a series of consecutive extensions of the temporary guardianship, before resolving by an agreement of the parties or Trial. If the Temporary Order becomes a permanent decree issued by the Court, the status of the case is closed. However, this does not terminate a parent's legal rights, as a parent retains the right to receive notice of any proceeding that is filed in the guardianship case. A parent also has the right to petition the Court to remove the guardian in the future.[114] Any time before the minor child becomes 18 years old and is a legal adult, any interested party may file a Petition or multiple Petitions to Remove (the Guardian).[115] The fundamental difference between temporary and permanent guardianship of a minor is the procedural status of the case with the Court. Temporary guardianships may be extended for a period of up to ninety (90) days unless otherwise specified by the Court. To the contrary, a permanent guardianship closes the status of the matter, with no further court hearings, until a Petition for Removal or Resignation (by the guardian) has been filed.

VI. Petitions for Removal or Resignation

A parent seeking to resume custody of his or her minor child may file a Petition for Removal of a Guardian. Additionally, a guardian who believes that the parent is able to care for the child may, on their own, file a Petition for Resignation. If all parties are not in agreement, the standard by which the Court has to determine whether to return custody is two-pronged:

(1) Whether the parent has provided credible evidence showing a change in circumstances from the initial guardianship appointment demonstrating that he or she is currently fit, and

(2) Whether the guardian has provided by clear and convincing evidence that the parent remains unfit and the guardianship continues to be in the minor child's best interest.[116]

Often, parents will consent to guardianship proceedings, which will be reflected in the permanent decree as the reason for guardianship, rather than parental unfitness or unavailability. This can be problematic for the courts, as a parent who is not fully recovered from his or her substance use disorder may still petition the Court to remove the guardian and regain their custody as a parent. Absent a finding of unfitness, a court may view the return of the child as appropriate, as little information about the parent's ongoing SUD may be contained in the Court file or presented at a hearing on the Petition to Remove the Guardian.

Due to a recent development in the law, effective April 12, 2021, permanent Guardians may apply for legal Counsel in Petitions for Removal. Guardians shall have the right to Counsel if the Court determines that (1) the Guardian has been the primary caretaker for the child for at least 2 years or for a significant period of time during the child's life, which may include time prior to or during the guardianship and (2) the Guardian meets the indigency requirements pursuant to Mass. Gen. Laws ch. 211D, §2A.

Guardians may file a Petition to Resign if they believe that either or both parents are able to resume the care and custody of the minor child. Such pleadings must be properly served, and a hearing is required prior to the termination of a permanent guardianship. The custody of the child reverts back to the Court's last custody Order (if there is an open matter) or Judgment. If

114 *See L.B. and another v. Chief Justice of the Probate and Family Court*, 474 Mass. 234, 244 (2016) (G. L. c. 190B, § 5-212 places no express limitation on how often a parent may file a petition to remove a guardian or to modify a guardianship. The Probate and Family Court might consider whether it is feasible and wise to create guidelines designed to discourage the filing of unnecessarily frequent petitions).
115 G. L. c. 190B, §5-212.
116 *Guardianship of Kelvin,* 94 Mass. App. Ct. 448 (2018).

there are modifications or paternity issues that need to be addressed in order for the guardianship to be terminated, those matters, and proceedings must be resolved prior to the entry of a Decree on the Petition for Removal or Resignation.

Children with parents with substance use disorders commonly experience significant, long-term effects associated with being separated from their immediate family and displaced from their home and school. Specifically, these children may endure severe emotional distress, including depression, anxiety, and behavioral issues. In order to manage their trauma, children with parents with a SUD will frequently act out when they enter their adolescent years.[117]

The continuation of a guardianship petition through potentially multiple extensions of Temporary Orders, often benefits one party but poses a risk to others involved. An extension of a Temporary Order for ninety (90) days may be insufficient for an adult to regain his or her sobriety, as the parent may require longer-term treatment, financial assistance, and housing. That same extension of time may seem inordinately long for a young child. Three months to a young child is an entire summer. This time may provide a sense of desperately needed stability for some or may feel like an endless period of uncertainty for others. Further, this timeframe may prolong the healing process for children who require emotional security and stability. Guardians are often unable to provide certainty for the minor children or even their own immediate families, as their role is dependent on a judicial review every ninety days. In many cases, there are also financial consequences, as many guardians do not receive adequate or consistent child support or sufficient contributions from the parents, in order to cover the costs of caring for the minor child.[118]

In an effort to promote long-term stability for families with parents with a SUD, courts should consider guardianship options in light of the totality of the circumstances, including the needs of the parents, children, and guardians; the traumatic effects of SUDs; and the long-term legal resolutions available. By focusing on long-term stabilization, courts have the power to decrease the number of future guardianship cases, as well as aid in the recovery of parents with SUDs, reduce the amount of adverse childhood experiences for their children,[119] and decrease domestic violence issues and drug-related offenses. The current caregivers, many of whom are older adults, could resume their roles as grandparents, relatives, or friends, and significantly reduce the number of successor guardianships needed to continue their appointments as well as new guardianships for future generations.

VIII. Discussion and Considerations

1. Provide parents with an SUD with the opportunity to become eligible to participate in specialty courts. Specifically, parents should be provided with the opportunity to participate in Family Drug Court to provide a pathway for recovery and basis for regaining custody.
2. Coordinate further collaboration of the Probate and Family Court and the Juvenile Court to continue developing a uniform approach to guardianships.
   - Provide parties with applications and information on legal representation for

117 Suzanne C. Brundage & Carol Levine, The Ripple Effect: The Impact of the Opioid Epidemic on Children and Families, 17 (2019), https://uhfnyc.org/media/filer_public/17/2c/172ca968-43aa-45f9-a290-50018e85a9d8/uhf-opioids-20190315.pdf.

118 Barbara Kaban & Virginia G. Weisz, Protecting Children, A Study of the Nature and Management of Guardianship of Minor Cases in the Probate and Family Court 28 (2008), nn.

119 Centers for Disease Control and Prevention, Adverse Childhood Experiences 1 (2003), www.cdc.gov/violenceprevention/childabuseandneglect/acestudy/index.html.

parents and interested parties, as allowed by statute and case law, request consistent reports from DCF throughout the guardianship process regarding progress of each parent, and maintain the focus on the long-term well-being of the child and the family unit.

- This approach would benefit families involved in guardianship matters, as well as preserve the Court's resources and ease the caseload of Court Appointed Counsel, who often serve both the Probate and Family Courts and the Juvenile Court.

3. Review the Court's guardianship forms and procedures. Where practical, consolidate information needed by the Court and required from the Petitioner.
    - Often, assistance is needed from the Registry staff, the Lawyer of the Day, or the Court Service Center. All of these resources are valuable and in high demand.
    - Consolidating information with fewer forms, if practical, would assist the Court in accessing valuable information more efficiently during an emergency hearing, and may provide Petitioners with a more user-friendly version of the current forms, requiring fewer Court resources to complete.
4. Refer cases to alternative dispute resolution (ADR), including permanency mediation services. Such services may be obtained on-site or in the community. They offer a means to resolve minor conflicts within the family during the guardianship process without the Court's involvement. Create agreements that provide long-term stability for minors in guardianship cases, in accordance with parental rights under the law.
5. Develop and provide greater access to Parent Programs and Mothers/Fathers Groups. Such groups may be offered through the Court's Probation Department and provide resources, support, and information to parents with pending guardianship cases.
6. Educate litigants and the community about the legal process, child support issues, and resources for parents, children, and caregivers that are offered by the Courts and other agencies. Other agencies include the Department of Revenue and the Department of Children and Families.

RESOURCES

Caregiver Affidavit Form: www.mps-edu.org/cms/lib/MA02212715/Centricity/domain/53/kindergarten%20registration/MA%20Caregiver%20Authorization%20Affidavit%20Inst-Form.pdf

Grandparents Raising Children: www.massgrg.com/massgrg_2019/index.html

Grandparents Raising Grandchildren, AARP: www.aarp.org/relationships/friends-family/info-08-2011/grandfamilies-guide-getting-started.html

Guardianship of Minors, Massachusetts: www.mass.gov/guardianship-of-minors

National Community Reinvestment Coalition: www.ncrc.org/resources-for-grand-parents-raising-grandchildren/

Chapter 10: Tips for Lawyers in Cases Involving Substance Use

Rachel B. Biscardi Esq., Northeast Legal Aid

I. Introduction

Sara,[120] a former client, was involved in a highly contested custody case with her child's father. Both parties accused the other of drug misuse. I had asked Sara several times whether she was taking any illegal drugs, to which she always replied that she was not. Finally, she admitted that she regularly used MDMA/ecstasy. However, she told me that she honestly believed that it was not important to tell me because she only used it at parties or after the child went to bed. As a newer attorney, I was dumbfounded. Why did it take so many times of asking her about drug use for her to disclose the truth, and how could she reasonably believe that her drug use, in the house with a child, was not directly relevant to her case? It is, in part, because of this story that I write this chapter to provide tips to those who interact with people who are accused of substance/alcohol issues in their family law cases.

II. Tip 1: Avoid Assumptions

Substance use issues can perplex the most senior of judges, attorneys, and medical practitioners. Every case is fact specific, and the person talking to you may have an entirely unique understanding of what constitutes a "serious" drug. In fact, I am frequently googling after a client meeting to learn more about a particular substance that was mentioned by my client. For lawyers, do not assume that your clients feel about substances/alcohol the way you do, or that they understand how a judge may feel about the frequency and use of illegal substances or alcohol. Have the conversation, as I did in the story above, about how the court may view alcohol or substance use, even if the client adamantly assures you that the substance in question is absolutely benign and does not affect their parenting. For court practitioners, do not assume that litigants always know that their behavior surrounding drugs or alcohol affects their parenting.

III. Tip 2: Get More Information

Understand the parents' background and circumstances when they are telling you about drug/alcohol use. Issues of poverty, culture, race, sexuality, and gender may play a significant role in their story. For lawyers, make sure you do not use inflammatory terms, such as "substance abuse problem," when referring to your client. Instead, ask for facts: type of substance, frequency of use, whether it is more of a social or solitary activity. If your client is the one accusing the other parent, also ask for facts. Is this a hunch? Was there a specific incident? You cannot rely on your client's vague sense that something is amiss. While your client may be correct, they will need

120 The client's name has been changed to protect anonymity.

to back up an allegation with a concrete rationale. Early warning signs may include being late to parenting exchanges, a recent firing, the parent leaving the child during their time with the child, or the child reporting slurred speech or unusual behavior.[121] Another marker that something may be wrong with a parent is if the child is frequently tardy to school during times that the child is with that parent. If your argument to the court relies on statements from the child and not first-hand parental observations, it is important to consider the age of the child. It is important to note that even though there may not be facts to support your client's claim, they may still be correct about the substance or alcohol use. In one case, I had no evidence to support my client's argument that the child's father was abusing drugs until he died of a drug overdose. Explain to your client that you can only present facts to the court, not hunches.

IV. Tip 3: Inform Clients About Drug Testing

For lawyers, assume that if your client wants the court to order the other party to undergo drug testing, it is probable that the court will require both parties to be tested. Make sure your client knows this ahead of time. It is hard to rehabilitate a client's credibility if the court views them as a hypocrite. For judges, it is not always intuitive to litigants that you may order both parties to be drug tested, especially if one of the parties does not think that they have a problem.

V. Tip 4: Clarify the Impact of Substance Use on Parenting

Assuming either party has a substance or alcohol use disorder, determine how that problem affects their parenting. For lawyers, clients frequently do not understand that judges have tremendous discretion to make orders that are in the child's best interest. Is there a nexus between the substance or alcohol use and neglectful parenting?[122] Is the accused parent exposing the child to a risky environment or risky associates? Is this a case where the judge can order a party to refrain from the use of alcohol or substances when the child is present or is the nature and extent of the use such that the court has to order a parent to completely abstain or change a custodial arrangement?

VI. Tip 5: Determine the Parent's Level of Acknowledgement of Substance Use Issues

Can you get the party using the alcohol or substances to acknowledge that they have a problem? For lawyers, if you can get the parties to agree on a plan that reassures the sober parent, you can present both the problem and the proposed solution to the court. Similar to most everything in the Probate Court, when lawyers present viable solutions to the judge, which are agreed upon by both parties, it is likely that the judge will approve it. An agreement also enables both parties to feel like they are in control of the situation and may be more likely to follow the plan. If there are financial or other impediments to recovery, think proactively about how to handle them and consider presenting them to the court.

VII. Tip 6: Gather More Information When a Parent with Substance Use Issues Does Not Recognize That They Have Substance Use Issues

In the more likely situation that a party denies that a problem exists, it is time to investigate.

121 Leo Sher, Research on the Neurobiology of Alcohol Use Disorders 17 (2008).

122 *See In re Adoption of Katherine*, 674 N.E.2d 256 (Mass. App. Ct. 1997) (refusing to permit adoption of children without the biological parent's consent and concluding that "[i]n the absence of a showing that a cocaine-using parent has been neglectful or abusive in the care of that parent's child, we do not think a cocaine habit, without more, translates automatically into legal unfitness to act as a parent.").

Does the opposing party have a criminal record that involves substance use? Have there been any DCF investigations, and has DCF supported the allegations of use or neglect? Are there witnesses to incidents involving use of substances or alcohol affecting parenting? For lawyers, if you can present to the court a credible argument of a past problem with indications that there is a current problem, you likely can meritoriously ask the court to order drug testing or alcohol screening. How old is the party? How long have they been misusing alcohol and/or illegal substances? Are there other people in the home with the accused parent who can provide the stability that a substance using parent may lack? What is the support structure for the child in general? For judges, does the accused parent have a support structure that may enable them to seek help? Is it possible to provide safeguards for the child around time with that parent?

VIII. Tip 7: Carefully Draft Agreements

Include parameters and repercussions in any agreement or judgment. For lawyers, since most cases settle in Probate Court, it is likely that a case involving a parent using alcohol or drugs will settle as well. Include definite language and structure in your agreement. Make sure that there are dates for when treatment should begin and what type of treatment. Include consequential language that details what happens if a parent fails a drug or alcohol screening. You do not want any ambiguity that may lead to a party filing a contempt for failure to allow parenting time. Even if the court ultimately dismisses that contempt, the child may lose the opportunity to share parenting time with the accused and your client has spent time, money, and energy to fight something that may have not needed court involvement if the consequences were included in the agreement. Include specific time parameters for how long a parent must wait if the other parent is late. Depending on the criminal history of the parties, you may want to have language regarding any new criminal involvement, such as what happens if the opposing party is arrested for an OUI, for example, rather than having to file for an emergency modification. Be mindful that once a case goes to judgment, the Probation Department of the Probate Court can no longer have an open case or monitor alcohol or drug testing. Thus, if you want access to test results, you will need to spell out how that will occur.

IX. Tip 8: Acknowledge Difficulties and Practical Realities of Taking on Cases Involving Substance Use

Cases involving issues of substance or alcohol use can be emotionally draining for all involved, especially if the parties still love each other, but cannot live together or co-parent due to the substance or alcohol use. As with any other case, try and minimize the acrimony and drama in order to find a way for the parties to resolve their issues, even if it is on a temporary basis. The parent who uses drugs or alcohol rarely does so just to hurt the other parent. Instead, the substance use is tragic for everyone involved: both parties, extended family, children, and yes, those lawyers, judges, and medical professionals who work with these families. If you find that your behavior and patience changes as a result of stressing about this kind of case, there are many outlets available to lawyers who experience vicarious trauma from their cases. Remember, that although we are professionals, committed to our clients and our practice, we are also human beings who make mistakes as well.

RESOURCES

Mass Legal Services: https://www.masslegalservices.org/content/family-law-advocacy-low-moderate-income-litigants

Substance Use Disorders and Mental Health Interest Group, American Bar Association: bit.ly/2NzvrnA

Chapter II: Judicial Perspective on Families Affected by Substance Use Disorder

Judge Beth A. Crawford (ret.), Franklin Family Drug Court

I. Introduction

It is important for judges to understand the key role they play in assisting parents in taking the first steps towards recovery. Judges should be encouraging and supportive of parents' recovery and should seek to develop rapport with them. Research shows that drug court participants are more likely to comply with treatment and have better outcomes when the judge communicates respect and support to them. When family treatment court (FTC) participants were asked to identify the most important elements of the program, participant/judge rapport ranked among the top six responses.[123] Frequent appearances before the court allows the judge to monitor recovery, continue to develop rapport with the litigant in recovery, and to review barriers to contact or reunification between a parent and child.

Judges should recognize that substance use disorder is a chronic, treatable disease, like diabetes or heart disease. They should keep in mind that those who suffer from SUD experience great shame and stigma related to their disease, and that stigma is a barrier to treatment. A judge establishes the tone and expectations of the court, and as such it is important for the judge to require that everyone be trained in the use of non-stigmatizing language related to SUD. For example, positive drug screens should not be referred to as "dirty," but rather the sample should be referred to as "positive" for a particular substance.

It is important for the judge to recognize the difference between a parent's lack of motivation to engage in SUD treatment and barriers to accessing services. In many cases what appears to be a lack of motivation is instead a lack of childcare, transportation, or health insurance coverage.

II. Drug Testing

Valid, reliable, random, observed, and frequent drug testing is an important tool for the family court judge. Testing should take place no fewer than two times per week and should include weekends. Urine collection must be witnessed by staff trained to monitor drug testing to ensure

123 Judge Leonard P. Edwards & Judge James A. Ray, *Judicial Perspectives on Family Drug Treatment Courts*, 56(3) Juv. and Fam. Ct. J. 1-27 (2005).

that specimens are not altered or substituted, and it should be conducted in a trauma-informed way.

It is important for judges to understand the limits on the type of information testing can provide. Drug tests alone are not enough to determine whether a parent has a substance use disorder, is able to parent safely, is under the influence of a substance, or is in recovery. Drug testing also cannot substantiate allegations of child abuse or neglect.[124] It is also important for the judge to understand the types of drug testing and their reliability. Most court-related drug testing uses an immunoassay to determine whether the specimen is positive for a prohibited substance. Because false positives are possible with this form of testing,[125] if the litigant denies use, this presumptively positive specimen should be further tested by gas chromatography-mass spectrometry (GC/MS) or liquid chromatography-mass spectrometry (LC/MS-MS) to confirm the results.[126] The same sample should always be confirmed through further testing of the same sample, not another immunoassay of a new sample.

A urine test may indicate dilution based upon the creatinine level in the specimen.[127] While dilution may raise a suspicion of tampering, it does not necessarily confirm tampering. Other factors need to be considered such as use of diuretics, a strict vegetarian diet, or maintaining a high level of hydration in hot weather.[128]

III. Diagnosing/Treating SUD

A diagnosis of substance use disorder is a clinical determination, not a legal determination. The legal determination to be made is whether there is a nexus between a parent's substance use and his or ability to care for the child. If SUD is diagnosed, treatment should be determined by a trained clinician based upon a standardized, objective assessment of the parent's treatment needs. This assessment first determines the level of care and how much structure and support a person is likely to need to attain stable recovery, and second, determines what kind of treatment the person requires, such as individual versus group treatment, trauma treatment, and use of medically assisted treatment (MAT). Treatment includes behavioral therapies, medications, and recovery supports. People with co-occurring SUDs and mental health disorders respond best by treating both disorders in an integrated manner.

Judges should keep in mind that only qualified health professionals can make determinations about the appropriateness or type of medication needed, and that use of medically assisted treatment alone is not treatment. Psychosocial supports, such as counseling and case management, should be delivered in conjunction with medications to treat SUD.[129] The Massachusetts Trial Court has issued a policy (MAT Policy Concerning the Use of Medications by Individuals Participating in Medication-Assisted Treatment, Executive Office of the Trial Court transmittal

124 Family Treatment Court Best Practice Standards 112 (2019), https://www.nadcp.org/wp-content/uploads/2019/09/Family-Treatment-Court-Best-Practice-Standards_Final2.pdf.
125 Substance Use and Mental Health Services Admin, Tap 32: Clinical Drug Testing in Primary Care (2012).
126 Family Treatment Court Best Practice Standards 99 (2019), https://www.nadcp.org/wp-content/uploads/2019/09/Family-Treatment-Court-Best-Practice-Standards_Final2.pdf.
127 Creatine is a naturally occurring substance in the body and is excreted in the urine.
128 Substance Use and Mental Health Services Admin, Tap 32: Clinical Drug Testing in Primary Care (2012).
129 *Medication and Counseling Treatment*, Substance Use and Mental Health Services Admin. https://www.samhsa.gov/medication-assisted-treatment/treatment (last updated Aug. 19, 2020).

20-5) that states that no court shall have a policy requiring that a person be prescribed medication as a condition of an order of parenting time. A judge retains the authority to monitor compliance with medication, but decisions about a person's medication type and dosage can only be made by a licensed prescriber.

IV. Trauma

It is important for judges to understand the relationship between SUD and trauma. Between 30% and 90% of women in SUD treatment have a history of physical and sexual abuse, depending on the definition of abuse and the population of focus.[130] More than 80% of female adult drug court participants were found to have experienced a serious traumatic event in their lifetime, more than half were in need of trauma-related services, and more than one-third met diagnostic criteria for PTSD.[131] Women in SUD treatment have two to four times the rate of partner violence as women in comparable community samples.[132] The rates of trauma for men seeking treatment for SUDs have been found to range from 42% to 95%.[133] As a rule of thumb, assume that everyone who appears before the court with a substance use disorder has experienced childhood or adult trauma. Be trauma informed in the words you choose, understanding that most people with substance use disorder have not had positive experiences in the courtroom.

It is also important to keep in mind that SUD is a family disease that affects children.

Children who are exposed to substance use in the home are five times more likely than other children to have experienced a traumatic event and to have a stress response to that event.[134] Equally important to remember is that children experience trauma when they are removed from their home. Judges have the opportunity to address this issue by helping caregivers understand that children may have experienced trauma and the importance of receiving treatment. Sesame Street has materials available to help young children cope with a traumatic experience and with parental SUD. Resources such as these, and referrals to community mental health programs that can provide trauma-informed services for children, can make a difference in how the child experiences parental SUD.

V. Return to Use

Finally, because SUD is a chronic disease, parents in recovery will sometimes return to use. As the Massachusetts Supreme Judicial Court so eloquently conveyed, treatment does not always work the first or even second time, and relapse should not be cause for giving up on an individual experiencing substance use disorder.[135] A return to use should not be considered a failure by the parent. Rather, a trained clinician should re-assess the parent and determine whether a higher level of care is necessary.

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130 Family Treatment Court Best Practices Standards 144 (2019), https://www.nadcp.org/wp-content/uploads/2019/09/Family-Treatment-Court-Best-Practice-Standards_Final2.pdf.
131 *Id.*
132 *Id.* at 146.
133 *Id.* at 144.
134 *Id.* at 143.
135 *Commonwealth v. Julie A. Eldred*, 480 Mass. 90 (July 2018).

Author Bios

Nicole Bell
Nicole Bell is the founder and Chief Executive Officer of Living in Freedom Together, Inc. (LIFT), a survivor-led, non-profit working to end prostitution and provide viable pathways out of the sex trade. Under Ms. Bell's leadership, LIFT opened Jana's Place, the first recovery home for women exiting prostitution with co-occurring substance use and mental health disorders in the nation. Further, Ms. Bell created the CATI (Creating Alternatives to Incarceration) Program, a pre-arraignment diversion program in partnership with the Worcester DA's Office. She has written trauma-informed curricula, and presents regionally and nationally on the Equality Model. Ms. Bell sits on the Executive Council for World Without Exploitation and was appointed to The Executive Office of Public Safety's Justice-Involved Women's Committee.

Rachel Biscardi, Esq.
Rachel Biscardi is Of Counsel at PiltserCowan Law, specializing in family law and abuse prevention order cases, after twenty years in legal services. Rachel served on the Legislative Task Force on Alimony which drafted the 2011 Alimony Reform Act. She also was a member of the Child Support Working Group that drafted the current Massachusetts Child Support Guidelines. She serves on the Trial Court's Domestic Violence Education Task Force, which is responsible for advising and assisting on domestic violence trainings for the trial court. Rachel was appointed to the Massachusetts Bar Association's Access to Justice Committee in 2014 and the Boston Bar Association's Family Law Steering Committee in 2009, and served as co-chair of the Domestic and Sexual Violence Coalition from 2008 to 2013. She regularly testifies in front of the legislature on family law bills focusing on child custody jurisdiction, alimony, and custody.

Hon. Beth A. Crawford
The Honorable Beth A. Crawford serves as the First Justice Franklin Probate and Family Court, where she opened Massachusetts' first family drug court. In 2017, the program was awarded a $2.1 million SAMSHA grant that allowed the Franklin Family Drug Court to be expanded to include child welfare cases from the Franklin/Hampshire Juvenile Court. Judge Crawford is a member of the Massachusetts Supreme Judicial Court's Working Group on Substance Use and Mental Health and a member of the New England Regional Judicial Opioid Initiative, where she co-chairs the Regional Resources committee. She is co-chair of the Massachusetts Probate and Family Court ADR Steering Committee and a past president of the Massachusetts Chapter of the Association of Family and Conciliation Courts.

Robin M. Deutsch, Ph.D., A.B.P.P
Dr. Robin Deutsch, former president of AFCC (2008) and former chair of the APA Ethics Committee, (2007) is board certified in couple and family psychology. She is a professor of clinical psychology at William James College and a former associate clinical professor of psychology at Harvard Medical School. She provides consultation, mediation, parenting coordination, and expert witness services in Wellesley, MA, and has published extensively on issues related to attachment, alienation, co-parenting after divorce, high-conflict divorce, parenting plans, and parenting coordination. In addition, Dr. Deutsch is co-editor with Abigail Judge of the book *Overcoming Parent-Child Contact Problems: Family-Based Interventions for Resistance, Rejection,*

Alienation (Oxford, 2016).

Alicia Doherty, Esq.
Alicia Doherty has been an attorney for over 20 years. She served as a law clerk and then the chief law clerk for the Massachusetts Probate and Family Court under Chief Justice Dunphy. Attorney Doherty has worked in the private sector and had her own solo practice from 2012 to 2016. She is a member of the Massachusetts Bar Association and the Worcester County Bar Association. Attorney Doherty serves on the Guardianship Committee for the Administrative Office of the Probate and Family Court, and is a board member of the Inn of Court and the American Families and Conciliation and Courts, Massachusetts Chapters. She has been an assistant judicial case manager for the Worcester Probate and Family Court since 2016.

Jordana Douglas, J.D.
Jordana Douglas is an attorney in Boston, Massachusetts and an Associate at Ropes & Gray LLP. She graduated from Northeastern University School of Law (NUSL) in 2020. During her time at NUSL, Ms. Douglas founded a student organization, the Mental Health Alliance, and hosted several events on the importance of empathetic lawyering, understanding trauma, and building rapport with clients. She is a board member of the Massachusetts chapter of the Association of Family and Conciliation Courts. She recently published an article in *Bender's Labor & Employment Bulletin* titled "Revisiting Hate Speech in the Workplace: Harmonizing the Employer's Conflicting Obligations Under Title VII and the National Labor Relations Act" (2020).

Jessica Greenwald O'Brien, Ph.D.
Jessica P. Greenwald O'Brien, Ph.D. is the director of the Center of Excellence for Children, Families and the Law. She attended the University of Michigan and then earned her doctorate in clinical and forensic psychology at the University of Nebraska. Her post-doctoral training in trauma and family forensics took place through the Victims of Violence Program at The Cambridge Hospital and the Children and the Law Program at Massachusetts General Hospital, both of the Harvard Medical School. She is also in private practice and conducts forensic evaluations with youth and families as well as consultation and teaching for attorneys and courts. She consults on topics of trauma and child maltreatment impacts on attachment, child development, parenting, delinquent behavior, and other special needs of children. Additionally, she has worked with teachers, school specialists, mental health professionals, and administrators to augment trauma sensitivity in their schools.

Abigail Judge, Ph.D.
Abigail Judge, Ph.D., is a clinical and forensic psychologist on staff at Massachusetts General Hospital and in private practice in Cambridge. Dr. Judge is also a part-time instructor at Harvard Medical School. Since 2009, she has worked with adolescents and adults impacted by commercial sexual exploitation in a range of roles: therapist, educator, court-appointed evaluator, and expert witness. Her hospital-based clinical work, scholarship, and teaching focuses on improving services for women impacted by the continuum of commercial sexual exploitation (CSE), e.g., survival sex, prostitution, sex trafficking, and substance use. Dr. Judge is piloting low-threshold services for women with opioid use disorder who are impacted by CSE at the MGH Bridge Clinic. This work has been supported by the Radcliffe Institute for Advanced Study at Harvard University and a Promoting Cultural Humility in Opioid Use Disorder Treatment Grant from the Office of the Massachusetts Attorney General. Dr. Judge is a 2020-2021 Fellow at the Center for Bioethics at Harvard Medical School.

Steven Paymer, M.S.W.
Steven Paymer has been at the forefront of drug and alcohol testing and monitoring on a national level for the last 15 years. He is the founder and president of Paymer Associates, LLC, and National Drug Testing Compliance and Management Co., LLC. The two companies are full service drug and alcohol testing and monitoring firms. The founding principle of his company is to bring testing and monitoring to the masses in a compassionate, professional, and non-judgmental manner. He has testified as an expert witness in over 50 cases in New York, Connecticut, Massachusetts, New Hampshire, and North Carolina, and has presented on the topic across the country and internationally. Mr. Paymer has spent most of the last twenty years working in the field of substance-use prevention and treatment. He received his master's degree in social work from Fordham University, and his B.A. in political science from the University of Colorado in Boulder. Prior to opening his company in 2006, he worked as a community advocate for adolescent substance use prevention and treatment and as a school social worker. He lives in Trumbull, CT, along with his two teenage daughters and his wife, Shannon.

Ruth Potee, M.D.
Dr. Ruth Potee is a board-certified Family Physician and Addiction Medicine physician who works in western Massachusetts. She attended Wellesley College and Yale University School of Medicine, and completed her residency at Boston University where she remained an assistant professor of Family Medicine for eight years. She is currently the medical director for the Franklin County House of Corrections, the director of Addiction Services for Behavioral Health Network, and the medical director for the Pioneer Valley Regional School District as well as the co-chair of the Healthcare Solutions Committee of the Opioid Task Force of Franklin County and the North Quabbin Region. She was named Franklin County Doctor of the Year by the Massachusetts Medical Society in 2015. Dr. Potee engages communities in discussions surrounding substance use through her wide-ranging series of talks.

Elizabeth Starck
Elizabeth Starck is working on her master's degree at the School of Social Work at Simmons University. She is a graduate of Bay Path University where she received a bachelor of arts in foundations of counseling. Elizabeth works as a recovery coach and peer specialist with Advocates, an organization that partners with individuals and families to provide support in navigating mental health and addiction challenges. Elizabeth previously struggled with alcoholism and mental health challenges. Elizabeth worked hard to build and maintain her recovery and regained shared custody of her son. She has four years of sobriety as of 2021.

Stephanie Tabashneck, Psy.D., Esq.
Dr. Stephanie Tabashneck is a psychologist and attorney in Wellesley, MA. Her practice areas include forensic psychological assessment, substance use issues, child custody, and criminal forensic evaluations. Dr. Tabashneck presents regionally and nationally on psychology and law topics, including at events organized by the American Bar Association, the Federal Judicial Center, the American Psychiatric Association, the Association of Family and Conciliation Courts, the Massachusetts Trial Courts, and the New York Office of Attorneys for Children. Dr. Tabashneck is a board member of the Massachusetts chapter of the Association of Family and Conciliation Courts. Recent publications include an article on the opioid crisis and family drug courts in the scholarly journal *Family Law Quarterly* (Spring 2019) and a chapter in the American Bar Association book *Representing People with Mental Disabilities: A Practical Guide for Criminal Defense Lawyers* (2019).

Appendix

Sample Order 1

COMMONWEALTH OF MASSACHUSETTS
The Trial Court
Probate and Family Division

Division Docket No. XXXXXXX

XXXXXX, Plaintiff

v.

XXXXXX, Defendant

JUDGMENT OF MODIFICATION

Upon the Complaint for Modification filed on January 11, 2021, after hearing on February 27, 2021, at which XXXX appeared and was self-represented and XXXXX did not appear and was not represented by counsel, in accordance with the temporary order dated December 15, 2020, the case was ordered to immediate trial. After hearing, the court **FINDS** that:

1. The father has failed to comply with the order dated December 15, 2020, requiring him to submit to random drug and alcohol screens. During this time period he should have completed eight random urine tests.

2. Based upon the father's behavior and the credible testimony of the mother, the court concludes that a material change of circumstances has occurred, and that the father has a substance use disorder that negatively affects his ability to parent.

Therefore, it is **ORDERED** that:

3. The father's obligation to submit to drug and alcohol screens is terminated.

4. The father shall continue to have parenting time every Wednesday. His parenting time shall be supervised by his mother, the child's paternal grandmother, who shall at all times be able to see and hear the child and shall assure that the father is not under the influence when the child is with him. If at any point prior to the scheduled parenting time the paternal grandmother suspects that the father is under the influence, she shall forthwith notify the mother and the parenting time will be in the mother's discretion either rescheduled or cancelled. The paternal grandmother may contact the Probation Office (XXX-XXX-XXXX) with any questions about her obligations as supervisor.

5. The mother shall provide transportation to and from the father's parenting time un less otherwise agreed by the mother and the paternal grandmother. The father shall at no time operate a motor vehicle with the child.

6. The father's parenting time may be expanded as agreed to by the mother, the father, and the paternal grandmother, but shall remain supervised until further order of the court.

7. The father is encouraged to seek treatment. The court is unlikely to expand the father's parenting time until he has completed a substance use treatment program. The father is encouraged to contact the Probation Office (XXX-XXX-XXXX) and/or the Opioid Task Force (https://www.opioidtaskforce.org/get-help/treatment-and-recovery-resources/) for referrals to substance use treatment and recovery resources.

Date: March 15, 2021

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XXXXXXX, Judge
Probate and Family Court

Sample Order 2

COMMONWEALTH OF MASSACHUSETTS
The Trial Court
Probate and Family Division

Division
XXXXXXX

Docket No.

XXXXXXXXX,
Plaintiff/Defendant-in-Counterclaim

v.

TEMPORARY ORDER APPOINTING GAL

XXXXXXXX,
Defendant/Plaintiff-in-Counterclaim

Upon the Complaint for Contempt filed on August 12, 2020, and counterclaim filed on September 16, 2020, after virtual hearings on January 14 and 15, 2021, at which XXXX appeared and was represented by XXXX, Esq. and XXXX appeared and was represented by XXXX, Esq., it is **ORDERED** that:

1. By separate order, XXXXXXXXXXXXX shall be appointed as guardian ad litem to evaluate and report to the court regarding the following issues:

    a. How are the children doing generally? Socially? Academically? Emotionally?

    b. Does the father have a substance use disorder? How does his substance use affect the children? How does the father's substance use affect the rest of his life, including but not limited to his ability to work? Is his substance use such that he can abstain when the children are in his care? What recommendations does the GAL have to ensure that the father abstains from substances during his parenting time?[136]

    c. Are the children afraid of the father? Has the mother unduly influenced the children? Has she caused or contributed to the children fearing the father? Has she behaved in any other way which negatively affects the children's relationship with the father?

    d. How do the children feel about spending time with each parent and in each household? Given the children's ages and maturity level, and potential for being influenced by either parent, what should the court consider in giving weight to such opinions?

    e. What parenting schedule is in the children's best interests? The court notes that the father is looking to increase his parenting time to include overnights and the mother wants the father's parenting time to be supervised.

136 The GAL is specifically authorized to conduct a substance use disorder assessment.

f. How are the parties communicating? Would the parties benefit from communicating using an online parent communication tool such as Our Family Wizard? Would they benefit from an educational program such as Only One Childhood? Are there any other resources that would benefit them?

g. Any other information and/or recommendations that the GAL believes to be relevant to the best interest or well-being of the child.

2. On or before May 20, 2021, the GAL shall file a written report with the court.

3. Each of the parties shall pay the GAL the fee of $1,500. The balance of the cost of the evaluation shall be paid by the Commonwealth of Massachusetts, subject to allocation after trial.

4. The court has not acted on the mother's motion requesting the father be required to submit to a hair follicle drug screen. Should the GAL request that either party submit to a hair follicle drug screen and a party not agree, the GAL may file a motion requesting a court order.

5. The GAL report shall be admitted into evidence subject to cross-examination.

6. The parties shall arrange to read the GAL report no less than 3 weeks prior to the pre trial conference, exchange written proposals for settlement no less than 2 weeks prior to the pretrial conference, and shall met in person no less than 1 week prior to hearing.

7. Counsel and each of the parties may receive a copy of the GAL report after signing a non-disclosure agreement with the probation office of this court. No one shall make any additional copies without further order. Within seven days of a judgment entering in this matter, all copies of the report shall be returned to the probation office.

8. The parties shall provide a list of all mental health/substance use providers from the last 5 years. The parties shall sign releases of information for the GAL to obtain all medical records, including records regarding mental health/substance use treatment.

9. A pretrial conference shall be held on June 29, 2021 at 9:00 a.m. A separate Pre-Trial Notice and Order shall issue.

Date: January 19, 2021

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XXXXXXX, Judge
Probate and Family Court

Sample Order 3

COMMONWEALTH OF MASSACHUSETTS
The Trial Court
Probate and Family Division

Division Docket No. XXXXXXX

XXXXX,
Plaintiff

v. TEMPORARY ORDER

XXXXX,
Defendant

Upon the Complaint for Modification filed on February 14, 2019, and counterclaim filed on January 28, 2020, after virtual hearing on December 16, 2020, at which XXXX appeared and was self-represented, XXXX appeared and was self-represented, and XXXXX, Esq. appeared on behalf of XXXX (born January 10, 2011), it is **ORDERED** that:

1. Beginning on December 17, 2020, XXXX shall reside primarily with the father, subject to the mother's parenting time as outlined below.

2. The mother shall have supervised parenting time with XXXX from 3 p.m. to 7 p.m. every Monday and Friday, beginning on Friday, December 18, 2020. Supervision shall be provided by XXXXXXXXX.

3. Upon the agreement of the parties, XXXX will spend from 11 a.m. until 7 p.m. on December 25, 2020, with the mother for supervised parenting time at the home of the maternal grandparents.

4. The mother agrees to continue submitting to alcohol screens using the SCRAM face-recognition, breathalyzer. She shall submit to a screen three to four times each day, including right before her parenting time and during her parenting time. The Probation Office shall determine the specific times at which the mother will be screened.

5. Should the mother miss a screen or test positive immediately prior to her parenting time or during her parenting time, her parenting time shall be suspended forthwith. The Probation Department will notify parties and counsel of the missed or positive test, and either of the parties may bring the matter back to Court by filing the appropriate pleadings.

6. Should the mother miss a screen or test positive at a time other than immediately prior to her parenting time or during her parenting time, both parties shall be notified, but her parenting time shall continue.

7. A pretrial conference shall be held on **Tuesday, April 6, 2021, at 9:00 a.m.**

8. On or before **May 30, 2021,** each party shall file an updated financial statement and a pretrial memorandum. Should either party need assistance, they may contact the Court Service Center at or @jud.state.ma.us.

9. At the June 6, 2021, hearing, the court will also consider the following:

    a. Whether a guardian *ad litem* should be appointed

10. Should either party fail to participate, the case may be dismissed, or the case may be ordered to immediate trial. Should both parties fail to participate, the case may be dismissed, or a judgment may enter incorporating the terms of any temporary orders currently in effect.

11. This order has been emailed to the parties.

Date: March 1, 2021

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XXXXXXX, Judge
Probate and Family Court

Sample Order 4

COMMONWEALTH OF MASSACHUSETTS
The Trial Court
Probate and Family Division

Division Docket No. XXXXXXX

XXXXX,
Plaintiff

v. **ORDER TO SUBMIT TO SUBSTANCE USE EVALUATION**

XXXXX,
Defendant

After hearing, the Court orders as follows:[137]
Parent shall, within 7 days, submit to a substance use evaluation by a Department of Transportation ("DOT") qualified Substance Abuse Professional ("SAP") and follow the process outlined below (rationale if needed: *the reason for this requirement is that similar to individuals employed by the DOT, parental responsibilities also require that they keep other individuals safe. Many substance use evaluations are limited in scope and only include self-report which results in limited data. It is necessary to use a highly qualified professional to perform the evaluation since the safety of children is the Court's foremost concern)*. The parties may agree, or the Court may permit upon a showing of good cause an alternative substance use professional to conduct the evaluation.

The evaluation process shall be as follows, and this order shall be provided to the evaluator:

a. Initial Evaluation: The evaluator completes a full biopsychosocial assessment on the client including information in all life domains (alcohol and substance use, mental health, medical, family, motivation, recovery environment, etc.) Evaluation should be made using the six dimensions of the American Society of Addiction Medicine's criteria and **should include verification of the parent report whenever possible and collateral contacts.**
b. Education/Treatment Recommendations: The evaluator makes a clinical recommendation for education and/or treatment that, if recommended, the client must complete. Client must comply with all recommendations by treatment providers (e.g., if the client enters high-intensity inpatient substance use treatment and the facility recommends residential treatment, the client must comply).
c. Follow-up Evaluation: Client meets with evaluator a second time to assess if the client has completed the education/treatment recommendations. If so, the parent is then eligible to resume unsupervised parenting time.
d. Period Follow-up Testing and Continuing Care Recommendation: The evaluator submits a Period Follow-up Testing schedule which must include a minimum of 24 drug tests within first 12 months, can be for up to 60 months. The evaluator may also state that the client must continue to engage in certain treatments, support groups, etc.
The evaluation shall be forwarded by the Probation Department to counsel for all parties via electronic mail, and Parent shall sign any releases necessary in order to effectuate this. In the

137 Sample order 4 was prepared with assistance from Michaela D. McCuish, Esq.

event there is no counsel, parties may view the results in the Probation Department.

Date: April 15, 2021

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XXXXXXX, Judge
Probate and Family Court

Sample Incremental Parenting Plan

Stephanie Tabashneck, Psy.D., Esq. Private Practice, Wellesley, MA

Drug and Alcohol Parenting Plan Roadmap

Monitoring of the Plan

It is recommended that the incremental parenting plan roadmap be monitored by a third party. Particular attention should be given to whether the next stage of lifted restrictions and increased parenting time is likely to be successful or pose a risk to [MINOR CHILD]. This decision should be made based on information obtained from the following sources: PARENT's therapist, medication prescriber, PARENT, CO-PARENT, and any other individual with firsthand knowledge of PARENT's sobriety or emotional well-being (*specify*).

For the first six months of the plan, it is recommended that on a weekly basis, PARENT email the parenting plan monitor the dates that they attended therapy, medical appointments, NA/AA meetings, and any other related appointments (e.g., meeting with sponsor, meeting with sober coach) (specify). Compliance with medication-assisted treatments is encouraged.

Sample Parenting Plan Roadmap[138]

Month One	Every Tuesday: 4:30 pm – 7:30 pm (Supervised) Every other Saturday: 8:00 am – 1:00 pm (Supervised) Every other Sunday: 8:00 am – 1:00 pm (Supervised)
Month Two	Every Tuesday: 4:30 pm – 7:30 pm (Supervised) Every other Saturday: 8:00 am – 1:00 pm (Unsupervised); 1:00 pm – 7:30 pm (Supervised)
Month Three	Every Tuesday: 4:30 pm – 7:30 pm (Supervised) Every other Saturday: 8:00 am – 1:00 pm (Unsupervised); 1:00 pm – 7:30 pm (Supervised) Every other Sunday: 8:00 am – 1:00 pm (Supervised); 1:00 pm – 7:30 pm (Unsupervised)
Month Four Month Five	Every Tuesday: 4:30 pm – 7:30 pm (Supervised) Every other Saturday: 8:00 am – 1:00 pm (Supervised); 1:00 pm – 7:30 pm (Unsupervised) [Overnight – Supervised from 7:30pm – 8:00am] Every other Sunday: 8:00 am – 7:30 pm (Unsupervised)
Month Six Month Seven	Every Tuesday: 4:30 pm – 7:30 pm (Unsupervised) Every other Saturday: 8:00 am – 7:30 pm (Unsupervised) [Overnight – Supervised from 7:30 pm – 8:00 am] Every other Sunday: 8:00 am – 7:30 pm (Unsupervised)

138 This sample roadmap parenting plan is for an individual at six months of sobriety who is working toward a 50/50 parenting plan with children age 11 and 12. The roadmap is flexible and responsive to the parent's progress. For example, if at "Month Seven" the parent is doing well and it is safe, the family could move on to "Month Nine" of the plan.

Month Eight Month Nine	Every Tuesday: 4:30 pm – 7:30 pm (Unsupervised) Every other Saturday: 8:00 am – 1:00 pm (Supervised); 1:00 pm – 7:30 pm (Unsupervised) [Overnight – Unsupervised from 7:30 pm – 8:00 am] Every other Sunday: 8:00 am – 7:30 pm (Unsupervised)
Month Ten Month Eleven	Every Tuesday: 4:30 pm – 7:30 pm (Unsupervised) Every Wednesday: 4:30 pm – 7:30 pm (Unsupervised) Every other Saturday: 8:00 am – 1:00 pm (Supervised); 1:00 pm – 7:30 pm (Unsupervised) [Overnight – Unsupervised from 7:30 pm – 8:00 am] Every other Sunday: 8:00 am – 7:30 pm (Unsupervised)
Month Twelve	Every Tuesday: 4:30 pm – overnight (Unsupervised) Every Wednesday: overnight – until 7:30 pm (Unsupervised) Every other Saturday: 8:00 am – overnight (Unsupervised) Every other Sunday: overnight – 7:30 pm (Unsupervised)
One Year	Full Implementation of Sample Parenting Plan below: [Adding every other Friday; overnight every other Sunday to Monday] Mon Tues Wed Thurs Fri Sat Sun Week 1: M M F F M M M Week 2: M M F F F F F

Post-12 Month Sample Parenting Plan #1
This sample parenting plan grants PARENT 7 days parenting time and CO-PARENT 7 days parenting time, every 14 days. The advantage of this plan is that MINOR CHILD will have access to both parents throughout the week. This plan includes several transitions but shortens the length of time away from each parent. In the event that conflict escalates between CO-PARENT and PARENT continues, this plan may prove difficult as it necessitates a moderate degree of communication and planning.

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Week 1:	M	M	F	F	M	M	M
Week 2:	M	M	F	F	F	F	F

Post-12 Month Sample Parenting Plan #2
Below is an alternative shared custody plan for PARENT and CO-PARENT with each parent granted 7 days of uninterrupted parenting time. A mid-week dinner with the non-custodial parent of the week is recommended. This parenting plan includes less transitions and would minimize the parents' need to communicate.

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Week 1:	M	M	M	M	M	M	M
Week 2:	F	F	F	F	F	F	F

Phone Calls During Parenting Plan Roadmap
It is recommended that the non-custodial parent have a scheduled video chat or phone call with MINOR CHILD each day. Depending on MINOR CHILD's age, these conversations can be brief (e.g., 2 minutes for younger children) or longer, as guided by MINOR CHILD's preferences when fully supported and encouraged by the custodial parent.

Sample Relapse Plan

Stephanie Tabashneck, Psy.D., Esq. Private Practice, Wellesley, MA

Pre-Relapse Communication

Given the chronic nature of addiction and mental illness, at times PARENT will be at heightened risk of relapse or mental health difficulties. If concerned about his/her emotional well-being, sobriety, or ability to care for MINOR CHILD, PARENT will immediately communicate these concerns with the parenting plan monitor and CO-PARENT. A temporary increase in supervision or step-down in parenting time may be warranted. This will give PARENT the time he/she/they need to troubleshoot what areas of treatment are not working and what additional supports are necessary. In the event PARENT engages in pre-relapse communication, he/she/they should be commended for proactively sharing that he/she/they are in need of extra support and actively managing his/her/their sobriety.

Relapse

In the event of a relapse, the following sample relapse plan is recommended:

I. PARENT immediately reports the relapse to the following individuals:
   1. Parent coordinator
   2. CO-PARENT
   3. NA/AA Sponsor
   4. Sober coach/drug coach/alcohol or drug counselor
   5. Therapist
   6. Nurse practitioner/physician/medication prescriber
   7. Other individuals in PARENT's support system (specify)

II. To the extent it is safe, PARENT and CO-PARENT will have joint conversation with MINOR CHILD (and therapist if possible) and explain that PARENT has had a setback, is proactively managing it, and that both parents are on the same team in helping PARENT to get better. The MINOR CHILD should be told that "Mom/dad loves you very much and will be less available for a little while so that they can work on being the best parent they can be." It will be important for MINOR CHILD to have a space to talk about their feelings regarding PARENT's absence.

III. PARENT will consult with treatment team (therapist, physician, sober coach/drug and alcohol coach) (specify) to determine the level of treatment intervention that is appropriate. If an intensive outpatient program is recommended, then PARENT will comply with the recommendations of the treatment team (therapist, physician, sober coach/drug and alcohol coach) (specify) and the recommendations of the program.
   a. Below is a list of three options for an intensive outpatient programs that PARENT has identified as a good fit for his/her/their needs and preferences:
      i. _____
      ii. _____
      iii. _____

IV. In the event of a relapse of extended duration and if a detox program is recommended, then PARENT will attend detox for the duration recommended by the treating physician/professional. It is strongly preferred that this detox is medically

supervised.[139]

a. Below is a list of three options for a detox program that PARENT has identified as a good fit for his/her/their needs and preferences:

i. _____
ii. _____
iii. _____

V. If an inpatient program is recommended, then PARENT will comply with the recommendations of the treatment team (therapist, physician, sober coach/drug and alcohol coach) (specify) and the recommendations of the program.

a. Below is a list of three options for inpatient programs:

i. _____
ii. _____
iii. _____

VI. Post-relapse, PARENT will continue to be allowed to have nightly phone calls as long as he/she/they are not under the influence of drug or alcohol during the phone call.

VII. Post-relapse, PARENT will be allowed twice weekly supervised visits of one-hour duration as long as they are not under the influence of drug or alcohol immediately before or during the visit. This decrease in parenting time will provide PARENT the time and space they need to focus on his/her/their sobriety, modify and adjust treatment, and ensure that their needs are met. The supervised parenting time should take place with any reasonable supervisor, (e.g., grandparent or family friend), an individual approved by the court or the parenting coordinator, or any individual approved by CO-PARENT.

VIII. After one month of sustained sobriety and consultation with PARENT's therapist, medication prescriber, PARENT, CO-PARENT, and any other individual with firsthand knowledge of PARENT's sobriety or emotional well-being (specify), if deemed appropriate, the parenting plan will resume beginning at Month One or a later Month, depending on the nature and severity of the relapse, communication pre-relapse and post-relapse, and the PARENT's current functioning.

139 Insurance issues should be troubleshooted ahead of time.

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