Bench Guide for Opioid-Involved Dependency Cases*†

An application of the current state of knowledge about opioid use disorders to the dependency court process

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* These guidelines are specific to opioid use cases and are in addition to broad judicial requirements/best practices at each stage of a dependency case. See Florida's Dependency Benchbook for comprehensive information regarding legal and non-legal matters in dependency cases. http://www.flcourts.org/resources-and-services/family-courts/dependency/dependency-benchbook.stml

† The information in these guidelines is organized around specific hearings and for brevity sake is not repeated across hearings. However, there is considerable overlap between the hearings regarding relevant information about opioids and potential judicial inquiry. The reader should view the hearing breakdowns with some flexibility. Created by Victoria Weisz, Ph.D., M.L.S. and Pamela Baston, MPA, MCAP, CPP from JBS International.

Florida Department of Children and Families · Office of Substance Abuse and Mental Health · MyFLFamilies.com

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Shelter Hearing

Can children remain safely in the home?

Facts about parental opioid use that may affect child safety:

- Prescription opioids and heroin have similar effects with some variability in effects related to the manner of ingestion;
- Fentanyl is a powerful synthetic opioid analgesic similar to morphine but 50-100 times more potent. Fentanyl's potency greatly increases risk of overdose especially if a person who uses it is unaware that the substance contains fentanyl;
- After an initial pleasurable "rush," people who use opioids will be very drowsy for several hours with clouded mental functioning;
- Repeated use often results in addiction — a chronic relapsing disease that is characterized by uncontrollable drug-seeking no matter the consequence. Seeking and using the drug becomes the primary purpose in life;
- Most people who use opioids also take other illicit substances that can adversely affect their health, safety, and daily functioning.

What case specific information does judge need to know?

- Has the parent developed an opioid or other substance use disorder?
- Was there information in the initial report (e.g. hotline abuse report) that indicated likely opioid or other substance use?
- Is there any information that parent might have experienced overdose in the past?
- Is there any criminal history of parent or other adults in home regarding opioid possession, sales, or use?
- How was information gathered regarding substance use?
  - Motivational interview with parent?
  - Did parent admit substance use problems?
  - Did collateral interviews provide information about substance use? Substance use lifestyle?
  - Did initial assessment include sufficient information gathering from collateral sources?
- Are there times that parent is sole caretaker of child and is using opioids?
- Are there any safety services available to prevent the removal?
- Do safety risks outweigh relative harm of removal?
- Are there voluntary services available to the parent to start treatment and possibly prevent removal?

Adjudication

Are there grounds for finding that the child has been abused or neglected or is at imminent risk of abuse or neglect?

Is there a nexus between opioid use and child abuse?

Facts about opioid misuse that may inform judgment about nexus:

- If parent has developed a moderate or severe opioid use disorder, then parent is likely:
  - Having periods of extreme drowsiness and clouded mental functioning lasting several hours;
  - Devoting considerable time to procuring, using, and recovering from the drug;
  - At risk for leaving opioid substances (e.g., heroin, pills) and/or paraphernalia (e.g., syringes, butane micro torches) accessible to children.

What case-specific information does judge need to know?

- Are there likely times that parent is sole caretaker of child and is using opioids?
- Would extreme parental drowsiness/cognitive impairment threaten child's immediate physical safety (e.g. feeding babies or other children, and supervising older babies and young children)?
- Would extreme parental drowsiness/cognitive impairment cause children to experience serious neglect and associated toxic stress (e.g. is baby left in playpen for several hour periods without caregiver interaction)?

Can child safely remain at home? If removed, can child have unsupervised visits?

- Is there another adult in the home who provides care when the parent is impaired?
- Is the child vulnerable because of age, temperament, or disability and is therefore unable to self-protect?
- Has the child demonstrated self-protection capacities regarding parental opioid use?
- Can child care for his/her own basic needs?

Disposition

Does the child need to remain in the custody of DCF?
Is DCF's permanency plan appropriate?
Is DCF making reasonable efforts to achieve that plan?

What is known about prognosis for opioid use/addiction? What is known about treatment? What is known about the capacity of people with opioid use disorder to enter and stay in recovery? What is known about relapses?

- Evidence exists that shows Medication-Assisted Treatment and Recovery (MAT-R) is very effective for people with opioid use disorders. These medications such as buprenorphine (e.g., Suboxone, Subutex) and methadone are not "replacing one addiction for another". They are prescribed or administered under monitored, controlled conditions and are safe and effective for treating opioid use disorder when used as directed by relieving withdrawal symptoms, reducing cravings, reducing overdose risk, and improving social functioning.
- Most individuals receiving MAT-R also need counseling to address underlying problems that contribute to drug use such as trauma, other mental health conditions, and unhealthy relationships and violence.
- Appropriate medication for opioid use disorders should not have adverse effects on intelligence, mental capability, or employability. If a person on MAT-R appears "high" they may also be using other substances.
- Another opioid medication, Naltrexone (e.g. Vivitrol), is also effective; however, patients must fully detox before starting it, and the associated discomfort can be a significant treatment barrier for many. Naltrexone is not right for everyone and can include risk of opioid overdose. Medical professionals will work with each person to help determine the best medication to address their individual needs.

What case specific information does the judge need to know?

- Does the case plan include evidence-based treatment that the parent can access?
- Does the case plan identify, and address concrete supports the parent needs to engage in treatment?
- Does the case plan identify other substances the parent is using/misusing? Are these adequately addressed?
- Does the case plan identify any co-occurring disorders/issues (e.g. mental health, domestic violence, chronic physical health problems)? Are these adequately addressed?
- Have children under age 3 been referred for a Part C (IDEA) evaluation?
- Are child developmental delays being addressed?
- Are mental health and/or substance use disorder issues addressed for older children and adolescents?

- Treatment effectiveness for substance abuse disorders is similar to treatment for chronic physical diseases such as diabetes, hypertension, and asthma.
- Relapse is common in all — although MAT-R effectively reduces relapse. Typically, relapse is an indication to re-adjust treatment. (With fentanyl in the mix now, relapses are more likely to be deadly.)
- MAT-R is the recommended standard of care for pregnant women with opioid use disorder. **Medical professionals** can prescribe pregnant women **certain** medications for opioid use disorder to effectively control withdrawal symptoms and stabilize maternal and fetal functions and minimize risks for return to substance use, overdose, and poor fetal health. Medical professionals should also inform the pregnant woman of the potential medical and social consequences of each form of therapy, specifically of the consequences that relate to neonatal abstinence syndrome (NAS) and unmonitored prenatal withdrawal.

Bottom line for judges — Many parents will enter and stay in recovery especially if they are provided MAT-R due to its demonstrated high levels of effectiveness.

What is known about needs of children who have suffered parental substance use disorders?

- If main caregiver has had a moderate or severe opioid use disorder for a long period of time, child is likely to have experienced significant neglect and toxic stress.
- Parent-child relationship is likely to be problematic and child may suffer from lack of a responsive parent.
- Parental sobriety, while crucial, will not necessarily by itself address child's or adolescent's developmental, mental health, or substance use disorder needs.
- Does the case plan include an evidence-based parenting program as part of or in addition to drug treatment?
- If neglect or drug exposure was significant, has the child-parent relationship been evaluated and is there a treatment plan to improve that relationship?

Judicial Review/Permanency Hearings

Is DCF's permanency plan appropriate?
Is DCF making reasonable efforts to achieve that plan?

What is known about opioids, parental capacity, prognosis?

- Parental substance use disorders, in general, can impair parenting capacity by:
  - Impairing parental cognitive functioning;
  - Reducing parental capacity to respond to a child's cues and needs;
  - Producing difficulties in regulating emotions and controlling impulsivity;
  - Disrupting healthy parent-child attachments;
  - Diverting limited funds to drugs rather than food or other needs;
  - Contributing to considerable time seeking out and using drugs;
  - Contributing to estrangement from family and other supports.
- Many parents will enter and stay in stable recovery especially if they are provided treatments that have demonstrated high levels of effectiveness (e.g., MAT-R).

What case specific information does judge need to know?

- Is parent engaged in evidence-based (MAT-R) opioid treatment? If yes:
  - When did parent begin treatment?
  - How is parent doing as shown in treatment provider report (e.g., report should include participation frequency, drug testing results, case management status, participation in mutual aid/12-step support; receiving recovery supports)?
  - Are co-occurring issues being adequately addressed?
  - Are there sufficient supports for child to safely return home?
  - Is there a safety plan for potential relapse (especially considering danger of overdose)?
- If parent is not engaged in evidence-based opioid treatment, why not (e.g., not available or lengthy administrative delays, transportation, financial or other barriers for parent, parent started but dropped out, parent failed to go)?
  - Are there reasonable efforts that can address any of these?
  - If reasonable efforts have been made, does the permanency plan of reunification need to be changed?
  - What is the concurrent plan?
- Is the parent engaged in an evidence-based parenting program? If yes:
  - Are there improvements seen in the program provider report?

  - Are there observable improvements to parent-child interactions/ relationship?

- If parent is not engaged in an evidence-based parenting program, why not (e.g., not available or lengthy administrative delays, transportation, financial or other barriers for parent, parent started but dropped out, parent failed to go)?
  - Are there reasonable efforts that can address any of these?
- Were any developmental, mental health, or substance use disorder issues identified for child or adolescent? If so, is child/adolescent receiving appropriate services?
- What is the nature of the child-parent relationship?

Termination of Parental Rights

If child has not yet been reunified with parent:

- Is parent engaged in evidence-based MAT-R?
  - If not, have reasonable efforts been made to get parent engaged in MAT-R?
- How is the parent doing as reported in the treatment provider report (e.g., report should include participation frequency, drug testing results, case management status, participation in mutual aid/12-step support; receiving recovery supports)?
- Was treatment availability delayed which might affect reasonable efforts and impact the ASFA "clock?"
- What is the quality of child-parent relationship?

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