ASSOCIATION OF FAMILY AND CONCILIATION COURTS

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NATIONAL COUNCIL OF JUVENILE AND FAMILY COURT JUDGES

AFCC AND NCJFCJ
JOINT STATEMENT ON PARENT-CHILD CONTACT PROBLEMS

Problem Statement:
The vast majority of separating and divorcing parents maintain safe, healthy, and positive relationships with their children; however, a small percentage of parent-child relationships remain strained and/or problematic. Children are at greater risk when parent-child contact problems are not effectively addressed and when family law professionals and others echo and intensify the polarization within the family. This problem may be exacerbated by (1) gendered and politicized assumptions that either parental alienation or intimate partner violence is the determinative issue; (2) contradictory rhetoric about the application of research findings and the efficacy of interventions; (3) indiscriminate use of services; and (4) a lack of understanding of different perspectives, education among family law practitioners, and resources.

AFCC and NCJFCJ support transparent, informed, and deliberate dialogue and response to parent-child contact problems following separation and divorce, or when the parents have never resided together, by adhering to the following considerations:

1. Adopt a child-centered approach
Children's behavior should be considered in the context of what is normal for a child's age, developmental stage, and the family socio-cultural-religious norms. This behavior may also be an expectable, adaptive reaction to stress, change, or an adverse childhood experience. The paramount focus of practitioners working with parent-child contact problems should be to promote the safety, interests, rights, and wellbeing of children and their parents/caregivers at all socioeconomic levels. Children should have the opportunity to express their views in family justice matters that concern them. The stated views of children are not necessarily determinative of their best interests. There are multiple factors that may contribute to children expressing views that do not reflect their best interests. Family justice practitioners should understand the basis for the child's expressed wishes and acknowledge their rights.

2. Increase competence in working with parent-child-contact problems
Specialized knowledge and skill are necessary to work effectively with families with parent-child contact problems. Family law practitioners should receive regular and ongoing training on the various factors related to parent-child contact problems including, but not limited to intimate partner violence, substance misuse, high conflict, denigration, parental alienating behaviors, and healthy parenting.

3. Screen for safety, conflict, and parent-child contact problems
In addition to initial and ongoing screening for safety, intimate partner violence and power-imbalances within families in all family law cases, parent-child contact issues, once identified, should be uniquely screened for safety and family risk factors, including the severity, frequency, and impact. Practitioners should, in all cases, employ a structured and evidence-informed screening for family risk factors.

4. Fully consider all factors that may contribute to parent-child contact problems
There should be no immediate label used for parent-child contact problems as there are multiple factors and dynamics that may account for these issues. These include interparental conflict before and after the separation, sibling relationships, the adversarial process/litigation, third parties such as aligned professionals and extended family, a lack of functional co-parenting, poor or conflictual parental communication, child maltreatment, a response to a parent's abusive behaviors, the direct or indirect exposure to intimate partner violence, parental alienating behaviors, an alignment with a parent in response to high conflict coparenting, or a combination of these factors. Therefore, practitioners should maintain a broad lens and sufficiently consider the relative contribution of each potential factor before conclusions are made about cause.

5. Conduct individual case analysis
Social science research findings can provide the field with valuable information about the group studied but cannot be used to determine the characteristics or experiences of individual parties or children; therefore, each family/case/situation must be specifically examined and informed by the best available evidence. Each case must be examined uniquely to understand the etiology and current dynamics of the problem for the family justice system to intervene in an effective child-focused manner.

6. Refer to appropriate and proportional services and interventions
Practitioners should exercise care in recommending, referring, or ordering family members to services and interventions. These services and interventions should be accessible, accountable, proportional to the nature and severity of factor(s) contributing to the parent-child contact problem(s), particularly when there is a court order requiring such services and interventions. Such services and interventions should be informed by a child-centered approach.

Approved by the AFCC Board of Directors, May 11, 2022
Approved by the NCJFCJ Board of Directors, June 15, 2022

Specialty Guidelines for Forensic Psychology

American Psychological Association

In the past 50 years forensic psychological practice has expanded dramatically. The American Psychological Association (APA) has a division devoted to matters of law and psychology (APA Division 41, the American Psychology–Law Society), a number of scientific journals devoted to interactions between psychology and the law exist (e.g., *Law and Human Behavior; Psychology, Public Policy, and Law; Behavioral Sciences & the Law*), and a number of key texts have been published and undergone multiple revisions (e.g., Grisso, 1986, 2003; Melton, Petrila, Poythress, & Slobogin, 1987, 1997, 2007; Rogers, 1988, 1997, 2008). In addition, training in forensic psychology is available in predoctoral, internship, and postdoctoral settings, and APA recognized forensic psychology as a specialty in 2001, with subsequent recertification in 2008.

Because the practice of forensic psychology differs in important ways from more traditional practice areas (Monahan, 1980) the "Specialty Guidelines for Forensic Psychologists" were developed and published in 1991 (Committee on Ethical Guidelines for Forensic Psychologists, 1991). Because of continued developments in the field in the ensuing 20 years, forensic practitioners' ongoing need for guidance, and policy requirements of APA, the 1991 "Specialty Guidelines for Forensic Psychologists" were revised, with the intent of benefiting forensic practitioners and recipients of their services alike.

The goals of these Specialty Guidelines for Forensic Psychology ("the Guidelines") are to improve the quality of forensic psychological services; enhance the practice and facilitate the systematic development of forensic psychology; encourage a high level of quality in professional practice; and encourage forensic practitioners to acknowledge and respect the rights of those they serve. These Guidelines are intended for use by psychologists when engaged in the practice of forensic psychology as described below and may also provide guidance on professional conduct to the legal system and other organizations and professions.

For the purposes of these Guidelines, *forensic psychology* refers to professional practice by any psychologist working within any subdiscipline of psychology (e.g., clinical, developmental, social, cognitive) when applying the scientific, technical, or specialized knowledge of psychology to the law to assist in addressing legal, contractual, and administrative matters. Application of the Guidelines does not depend on the practitioner's typical areas of practice or expertise, but rather, on the service provided in the case at hand. These Guidelines apply in all matters in which psychologists provide expertise to judicial, administrative, and educational systems including, but not limited to, examining or treating persons in anticipation of or subsequent to legal, contractual, or administrative proceedings; offering expert opinion about psychological issues in the form of amicus briefs or testimony to judicial, legislative, or administrative bodies; acting in an adjudicative capacity; serving as a trial consultant or otherwise offering expertise to attorneys, the courts, or others; conducting research in connection with, or in the anticipation of, litigation; or involvement in educational activities of a forensic nature.

Psychological practice is not considered forensic solely because the conduct takes place in, or the product is presented in, a tribunal or other judicial, legislative, or administrative forum. For example, when a party (such as a civilly or criminally detained individual) or another individual (such as a child whose parents are involved in divorce proceedings) is ordered into treatment with a practitioner, that treatment is not necessarily the practice of forensic psychology. In addition, psychological testimony that is solely based on the provision of psychotherapy and does not include psycholegal opinions is not ordinarily considered forensic practice.

For the purposes of these Guidelines, *forensic practitioner* refers to a psychologist when engaged in the practice of forensic psychology as described above. Such professional conduct is considered forensic from the time the practitioner reasonably expects to, agrees to, or is legally mandated to provide expertise on an explicitly psycholegal issue.

The provision of forensic services may include a wide variety of psycholegal roles and functions. For example, as

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These Specialty Guidelines for Forensic Psychology were developed by the American Psychology–Law Society (Division 41 of the American Psychological Association [APA]) and the American Academy of Forensic Psychology. They were adopted by the APA Council of Representatives on August 3, 2011.

The previous version of the Guidelines ("Specialty Guidelines for Forensic Psychologists"; Committee on Ethical Guidelines for Forensic Psychologists, 1991) was approved by the American Psychology–Law Society (Division 41 of APA) and the American Academy of Forensic Psychology in 1991. The current revision, now called the "Specialty Guidelines for Forensic Psychology" (referred to as "the Guidelines" throughout this document), replaces the 1991 "Specialty Guidelines for Forensic Psychologists."

These guidelines are scheduled to expire August 3, 2021. After this date, users are encouraged to contact the American Psychological Association Practice Directorate to confirm that this document remains in effect.

Correspondence concerning these guidelines should be addressed to the Practice Directorate, American Psychological Association, 750 First Street, NE, Washington, DC 20002-4242.

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researchers, forensic practitioners may participate in the collection and dissemination of data that are relevant to various legal issues. As advisors, forensic practitioners may provide an attorney with an informed understanding of the role that psychology can play in the case at hand. As consultants, forensic practitioners may explain the practical implications of relevant research, examination findings, and the opinions of other psycholegal experts. As examiners, forensic practitioners may assess an individual's functioning and report findings and opinions to the attorney, a legal tribunal, an employer, an insurer, or others (APA, 2010b, 2011a). As treatment providers, forensic practitioners may provide therapeutic services tailored to the issues and context of a legal proceeding. As mediators or negotiators, forensic practitioners may serve in a third-party neutral role and assist parties in resolving disputes. As arbiters, special masters, or case managers with decision-making authority, forensic practitioners may serve parties, attorneys, and the courts (APA, 2011b).

These Guidelines are informed by APA's "Ethical Principles of Psychologists and Code of Conduct" (hereinafter referred to as the EPPCC; APA, 2010a). The term *guidelines* refers to statements that suggest or recommend specific professional behavior, endeavors, or conduct for psychologists. Guidelines differ from standards in that standards are mandatory and may be accompanied by an enforcement mechanism. Guidelines are aspirational in intent. They are intended to facilitate the continued systematic development of the profession and facilitate a high level of practice by psychologists. Guidelines are not intended to be mandatory or exhaustive and may not be applicable to every professional situation. They are not definitive, and they are not intended to take precedence over the judgment of psychologists.

As such, the Guidelines are advisory in areas in which the forensic practitioner has discretion to exercise professional judgment that is not prohibited or mandated by the EPPCC or applicable law, rules, or regulations. The Guidelines neither add obligations to nor eliminate obligations from the EPPCC but provide additional guidance for psychologists. The modifiers used in the Guidelines (e.g., *reasonably, appropriate, potentially*) are included in recognition of the need for professional judgment on the part of forensic practitioners; ensure applicability across the broad range of activities conducted by forensic practitioners; and reduce the likelihood of enacting an inflexible set of guidelines that might be inapplicable as forensic practice evolves. The use of these modifiers, and the recognition of the role of professional discretion and judgment, also reflects that forensic practitioners are likely to encounter facts and circumstances not anticipated by the Guidelines and they may have to act upon uncertain or incomplete evidence. The Guidelines may provide general or conceptual guidance in such circumstances. The Guidelines do not, however, exhaust the legal, professional, moral, and ethical considerations that inform forensic practitioners, for no complex activity can be completely defined by legal rules, codes of conduct, and aspirational guidelines.

The Guidelines are not intended to serve as a basis for disciplinary action or civil or criminal liability. The standard of care is established by a competent authority, not by the Guidelines. No ethical, licensure, or other administrative action or remedy, nor any other cause of action, should be taken *solely* on the basis of a forensic practitioner acting in a manner consistent or inconsistent with these Guidelines.

In cases in which a competent authority references the Guidelines when formulating standards, the authority should consider that the Guidelines attempt to identify a high level of quality in forensic practice. Competent practice is defined as the conduct of a reasonably prudent forensic practitioner engaged in similar activities in similar circumstances. Professional conduct evolves and may be viewed along a continuum of adequacy, and "minimally competent" and "best possible" are usually different points along that continuum.

The Guidelines are designed to be national in scope and are intended to be consistent with state and federal law. In cases in which a conflict between legal and professional obligations occurs, forensic practitioners make known their commitment to the EPPCC and the Guidelines and take steps to achieve an appropriate resolution consistent with the EPPCC and the Guidelines.

The format of the Guidelines is different from most other practice guidelines developed under the auspices of APA. This reflects the history of the Guidelines as well as the fact that the Guidelines are considerably broader in scope than any other APA-developed guidelines. Indeed, these are the only APA-approved guidelines that address a complete specialty practice area. Despite this difference in format, the Guidelines function as all other APA guideline documents.

This document replaces the 1991 "Specialty Guidelines for Forensic Psychologists," which were approved by the American Psychology–Law Society (Division 41 of APA) and the American Board of Forensic Psychology. The current revision has also been approved by the Council of Representatives of APA. Appendix A includes a discussion of the revision process, enactment, and current status of these Guidelines. Appendix B includes definitions and terminology as used for the purposes of these Guidelines.

1. Responsibilities

Guideline 1.01: Integrity

Forensic practitioners strive for accuracy, honesty, and truthfulness in the science, teaching, and practice of forensic psychology and they strive to resist partisan pressures to provide services in any ways that might tend to be misleading or inaccurate.

Guideline 1.02: Impartiality and Fairness

When offering expert opinion to be relied upon by a decision maker, providing forensic therapeutic services, or teaching or conducting research, forensic practitioners strive for accuracy, impartiality, fairness, and independence (EPPCC Standard 2.01). Forensic practitioners rec-

ognize the adversarial nature of the legal system and strive to treat all participants and weigh all data, opinions, and rival hypotheses impartially.

When conducting forensic examinations, forensic practitioners strive to be unbiased and impartial, and avoid partisan presentation of unrepresentative, incomplete, or inaccurate evidence that might mislead finders of fact. This guideline does not preclude forceful presentation of the data and reasoning upon which a conclusion or professional product is based.

When providing educational services, forensic practitioners seek to represent alternative perspectives, including data, studies, or evidence on both sides of the question, in an accurate, fair and professional manner, and strive to weigh and present all views, facts, or opinions impartially.

When conducting research, forensic practitioners seek to represent results in a fair and impartial manner. Forensic practitioners strive to utilize research designs and scientific methods that adequately and fairly test the questions at hand, and they attempt to resist partisan pressures to develop designs or report results in ways that might be misleading or unfairly bias the results of a test, study, or evaluation.

Guideline 1.03: Avoiding Conflicts of Interest

Forensic practitioners refrain from taking on a professional role when personal, scientific, professional, legal, financial, or other interests or relationships could reasonably be expected to impair their impartiality, competence, or effectiveness, or expose others with whom a professional relationship exists to harm (EPPCC Standard 3.06).

Forensic practitioners are encouraged to identify, make known, and address real or apparent conflicts of interest in an attempt to maintain the public confidence and trust, discharge professional obligations, and maintain responsibility, impartiality, and accountability (EPPCC Standard 3.06). Whenever possible, such conflicts are revealed to all parties as soon as they become known to the psychologist. Forensic practitioners consider whether a prudent and competent forensic practitioner engaged in similar circumstances would determine that the ability to make a proper decision is likely to become impaired under the immediate circumstances.

When a conflict of interest is determined to be manageable, continuing services are provided and documented in a way to manage the conflict, maintain accountability, and preserve the trust of relevant others (also see Guideline 4.02 below).

2. Competence

Guideline 2.01: Scope of Competence

When determining one's competence to provide services in a particular matter, forensic practitioners may consider a variety of factors including the relative complexity and specialized nature of the service, relevant training and experience, the preparation and study they are able to devote to the matter, and the opportunity for consultation with a professional of established competence in the subject matter in question. Even with regard to subjects in which they are expert, forensic practitioners may choose to consult with colleagues.

Guideline 2.02: Gaining and Maintaining Competence

Competence can be acquired through various combinations of education, training, supervised experience, consultation, study, and professional experience. Forensic practitioners planning to provide services, teach, or conduct research involving populations, areas, techniques, or technologies that are new to them are encouraged to undertake relevant education, training, supervised experience, consultation, or study.

Forensic practitioners make ongoing efforts to develop and maintain their competencies (EPPCC Standard 2.03). To maintain the requisite knowledge and skill, forensic practitioners keep abreast of developments in the fields of psychology and the law.

Guideline 2.03: Representing Competencies

Consistent with the EPPCC, forensic practitioners adequately and accurately inform all recipients of their services (e.g., attorneys, tribunals) about relevant aspects of the nature and extent of their experience, training, credentials, and qualifications, and how they were obtained (EPPCC Standard 5.01).

Guideline 2.04: Knowledge of the Legal System and the Legal Rights of Individuals

Forensic practitioners recognize the importance of obtaining a fundamental and reasonable level of knowledge and understanding of the legal and professional standards, laws, rules, and precedents that govern their participation in legal proceedings and that guide the impact of their services on service recipients (EPPCC Standard 2.01).

Forensic practitioners aspire to manage their professional conduct in a manner that does not threaten or impair the rights of affected individuals. They may consult with, and refer others to, legal counsel on matters of law. Although they do not provide formal legal advice or opinions, forensic practitioners may provide information about the legal process to others based on their knowledge and experience. They strive to distinguish this from legal opinions, however, and encourage consultation with attorneys as appropriate.

Guideline 2.05: Knowledge of the Scientific Foundation for Opinions and Testimony

Forensic practitioners seek to provide opinions and testimony that are sufficiently based upon adequate scientific foundation, and reliable and valid principles and methods that have been applied appropriately to the facts of the case.

When providing opinions and testimony that are based on novel or emerging principles and methods, forensic practitioners seek to make known the status and limitations of these principles and methods.

Guideline 2.06: Knowledge of the Scientific Foundation for Teaching and Research

Forensic practitioners engage in teaching and research activities in which they have adequate knowledge, experience, and education (EPPCC Standard 2.01), and they acknowledge relevant limitations and caveats inherent in procedures and conclusions (EPPCC Standard 5.01).

Guideline 2.07: Considering the Impact of Personal Beliefs and Experience

Forensic practitioners recognize that their own cultures, attitudes, values, beliefs, opinions, or biases may affect their ability to practice in a competent and impartial manner. When such factors may diminish their ability to practice in a competent and impartial manner, forensic practitioners may take steps to correct or limit such effects, decline participation in the matter, or limit their participation in a manner that is consistent with professional obligations.

Guideline 2.08: Appreciation of Individual and Group Differences

When scientific or professional knowledge in the discipline of psychology establishes that an understanding of factors associated with age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, socioeconomic status, or other relevant individual and cultural differences affects implementation or use of their services or research, forensic practitioners consider the boundaries of their expertise, make an appropriate referral if indicated, or gain the necessary training, experience, consultation, or supervision (EPPCC Standard 2.01; APA, 2003, 2004, 2011c, 2011d, 2011e).

Forensic practitioners strive to understand how factors associated with age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, socioeconomic status, or other relevant individual and cultural differences may affect and be related to the basis for people's contact and involvement with the legal system.

Forensic practitioners do not engage in unfair discrimination based on such factors or on any basis proscribed by law (EPPCC Standard 3.01). They strive to take steps to correct or limit the effects of such factors on their work, decline participation in the matter, or limit their participation in a manner that is consistent with professional obligations.

Guideline 2.09: Appropriate Use of Services and Products

Forensic practitioners are encouraged to make reasonable efforts to guard against misuse of their services and exercise professional discretion in addressing such misuses.

3. Diligence

Guideline 3.01: Provision of Services

Forensic practitioners are encouraged to seek explicit agreements that define the scope of, time-frame of, and compensation for their services. In the event that a client breaches the contract or acts in a way that would require the practitioner to violate ethical, legal or professional obligations, the forensic practitioner may terminate the relationship.

Forensic practitioners strive to act with reasonable diligence and promptness in providing agreed-upon and reasonably anticipated services. Forensic practitioners are not bound, however, to provide services not reasonably anticipated when retained, nor to provide every possible aspect or variation of service. Instead, forensic practitioners may exercise professional discretion in determining the extent and means by which services are provided and agreements are fulfilled.

Guideline 3.02: Responsiveness

Forensic practitioners seek to manage their workloads so that services can be provided thoroughly, competently, and promptly. They recognize that acting with reasonable promptness, however, does not require the forensic practitioner to acquiesce to service demands not reasonably anticipated at the time the service was requested, nor does it require the forensic practitioner to provide services if the client has not acted in a manner consistent with existing agreements, including payment of fees.

Guideline 3.03: Communication

Forensic practitioners strive to keep their clients reasonably informed about the status of their services, comply with their clients' reasonable requests for information, and consult with their clients about any substantial limitation on their conduct or performance that may arise when they reasonably believe that their clients expect a service that is not consistent with their professional obligations. Forensic practitioners attempt to keep their clients reasonably informed regarding new facts, opinions, or other potential evidence that may be relevant and applicable.

Guideline 3.04: Termination of Services

The forensic practitioner seeks to carry through to conclusion all matters undertaken for a client unless the forensic practitioner–client relationship is terminated. When a forensic practitioner's employment is limited to a specific matter, the relationship may terminate when the matter has been resolved, anticipated services have been completed, or the agreement has been violated.

4. Relationships

Whether a forensic practitioner–client relationship exists depends on the circumstances and is determined by a number of factors which may include the information exchanged between the potential client and the forensic practitioner prior to, or at the initiation of, any contact or service, the nature of the interaction, and the purpose of the interaction.

In their work, forensic practitioners recognize that relationships are established with those who retain their services (e.g., retaining parties, employers, insurers, the

court) and those with whom they interact (e.g., examinees, collateral contacts, research participants, students). Forensic practitioners recognize that associated obligations and duties vary as a function of the nature of the relationship.

Guideline 4.01: Responsibilities to Retaining Parties

Most responsibilities to the retaining party attach only after the retaining party has requested and the forensic practitioner has agreed to render professional services and an agreement regarding compensation has been reached. Forensic practitioners are aware that there are some responsibilities, such as privacy, confidentiality, and privilege, that may attach when the forensic practitioner agrees to consider whether a forensic practitioner–retaining party relationship shall be established. Forensic practitioners, prior to entering into a contract, may direct the potential retaining party not to reveal any confidential or privileged information as a way of protecting the retaining party's interest in case a conflict exists as a result of pre-existing relationships.

At the initiation of any request for service, forensic practitioners seek to clarify the nature of the relationship and the services to be provided including the role of the forensic practitioner (e.g., trial consultant, forensic examiner, treatment provider, expert witness, research consultant); which person or entity is the client; the probable uses of the services provided or information obtained; and any limitations to privacy, confidentiality, or privilege.

Guideline 4.02: Multiple Relationships

A multiple relationship occurs when a forensic practitioner is in a professional role with a person and, at the same time or at a subsequent time, is in a different role with the same person; is involved in a personal, fiscal, or other relationship with an adverse party; at the same time is in a relationship with a person closely associated with or related to the person with whom the forensic practitioner has the professional relationship; or offers or agrees to enter into another relationship in the future with the person or a person closely associated with or related to the person (EPPCC Standard 3.05).

Forensic practitioners strive to recognize the potential conflicts of interest and threats to objectivity inherent in multiple relationships. Forensic practitioners are encouraged to recognize that some personal and professional relationships may interfere with their ability to practice in a competent and impartial manner and they seek to minimize any detrimental effects by avoiding involvement in such matters whenever feasible or limiting their assistance in a manner that is consistent with professional obligations.

Guideline 4.02.01: Therapeutic–Forensic Role Conflicts

Providing forensic and therapeutic psychological services to the same individual or closely related individuals involves multiple relationships that may impair objectivity and/or cause exploitation or other harm. Therefore, when requested or ordered to provide either concurrent or sequential forensic and therapeutic services, forensic practitioners are encouraged to disclose the potential risk and make reasonable efforts to refer the request to another qualified provider. If referral is not possible, the forensic practitioner is encouraged to consider the risks and benefits to all parties and to the legal system or entity likely to be impacted, the possibility of separating each service widely in time, seeking judicial review and direction, and consulting with knowledgeable colleagues. When providing both forensic and therapeutic services, forensic practitioners seek to minimize the potential negative effects of this circumstance (EPPCC Standard 3.05).

Guideline 4.02.02: Expert Testimony by Practitioners Providing Therapeutic Services

Providing expert testimony about a patient who is a participant in a legal matter does not necessarily involve the practice of forensic psychology even when that testimony is relevant to a psycholegal issue before the decision maker. For example, providing testimony on matters such as a patient's reported history or other statements, mental status, diagnosis, progress, prognosis, and treatment would not ordinarily be considered forensic practice even when the testimony is related to a psycholegal issue before the decision maker. In contrast, rendering opinions and providing testimony about a person on psycholegal issues (e.g., criminal responsibility, legal causation, proximate cause, trial competence, testamentary capacity, the relative merits of parenting arrangements) would ordinarily be considered the practice of forensic psychology.

Consistent with their ethical obligations to base their opinions on information and techniques sufficient to substantiate their findings (EPPCC Standards 2.04, 9.01), forensic practitioners are encouraged to provide testimony only on those issues for which they have adequate foundation and only when a reasonable forensic practitioner engaged in similar circumstances would determine that the ability to make a proper decision is unlikely to be impaired. As with testimony regarding forensic examinees, the forensic practitioner strives to identify any substantive limitations that may affect the reliability and validity of the facts or opinions offered, and communicates these to the decision maker.

Guideline 4.02.03: Provision of Forensic Therapeutic Services

Although some therapeutic services can be considered forensic in nature, the fact that therapeutic services are ordered by the court does not necessarily make them forensic.

In determining whether a therapeutic service should be considered the practice of forensic psychology, psychologists are encouraged to consider the potential impact of the legal context on treatment, the potential for treatment to impact the psycholegal issues involved in the case, and whether another reasonable psychologist in a similar position would consider the service to be forensic and these Guidelines to be applicable.

Therapeutic services can have significant effects on current or future legal proceedings. Forensic practitioners

are encouraged to consider these effects and minimize any unintended or negative effects on such proceedings or therapy when they provide therapeutic services in forensic contexts.

Guideline 4.03: Provision of Emergency Mental Health Services to Forensic Examinees

When providing forensic examination services an emergency may arise that requires the practitioner to provide short-term therapeutic services to the examinee in order to prevent imminent harm to the examinee or others. In such cases the forensic practitioner is encouraged to limit disclosure of information and inform the retaining attorney, legal representative, or the court in an appropriate manner. Upon providing emergency treatment to examinees, forensic practitioners consider whether they can continue in a forensic role with that individual so that potential for harm to the recipient of services is avoided (EPPCC Standard 3.04).

5. Fees

Guideline 5.01: Determining Fees

When determining fees forensic practitioners may consider salient factors such as their experience providing the service, the time and labor required, the novelty and difficulty of the questions involved, the skill required to perform the service, the fee customarily charged for similar forensic services, the likelihood that the acceptance of the particularba employment will preclude other employment, the time limitations imposed by the client or circumstances, the nature and length of the professional relationship with the client, the client's ability to pay for the service, and any legal requirements.

Guideline 5.02: Fee Arrangements

Forensic practitioners are encouraged to make clear to the client the likely cost of services whenever it is feasible, and make appropriate provisions in those cases in which the costs of services is greater than anticipated or the client's ability to pay for services changes in some way.

Forensic practitioners seek to avoid undue influence that might result from financial compensation or other gains. Because of the threat to impartiality presented by the acceptance of contingent fees and associated legal prohibitions, forensic practitioners strive to avoid providing professional services on the basis of contingent fees. Letters of protection, financial guarantees, and other security for payment of fees in the future are not considered contingent fees unless payment is dependent on the outcome of the matter.

Guideline 5.03: Pro Bono Services

Forensic psychologists recognize that some persons may have limited access to legal services as a function of financial disadvantage and strive to contribute a portion of their professional time for little or no compensation or personal advantage (EPPCC Principle E).

6. Informed Consent, Notification, and Assent

Because substantial rights, liberties, and properties are often at risk in forensic matters, and because the methods and procedures of forensic practitioners are complex and may not be accurately anticipated by the recipients of forensic services, forensic practitioners strive to inform service recipients about the nature and parameters of the services to be provided (EPPCC Standards 3.04, 3.10).

Guideline 6.01: Timing and Substance

Forensic practitioners strive to inform clients, examinees, and others who are the recipients of forensic services as soon as is feasible about the nature and extent of reasonably anticipated forensic services.

In determining what information to impart, forensic practitioners are encouraged to consider a variety of factors including the person's experience or training in psychological and legal matters of the type involved and whether the person is represented by counsel. When questions or uncertainties remain after they have made the effort to explain the necessary information, forensic practitioners may recommend that the person seek legal advice.

Guideline 6.02: Communication With Those Seeking to Retain a Forensic Practitioner

As part of the initial process of being retained, or as soon thereafter as previously unknown information becomes available, forensic practitioners strive to disclose to the retaining party information that would reasonably be anticipated to affect a decision to retain or continue the services of the forensic practitioner.

This disclosure may include, but is not limited to, the fee structure for anticipated services; prior and current personal or professional activities, obligations, and relationships that would reasonably lead to the fact or the appearance of a conflict of interest; the forensic practitioner's knowledge, skill, experience, and education relevant to the forensic services being considered, including any significant limitations; and the scientific bases and limitations of the methods and procedures which are expected to be employed.

Guideline 6.03: Communication With Forensic Examinees

Forensic practitioners inform examinees about the nature and purpose of the examination (EPPCC Standard 9.03; American Educational Research Association, American Psychological Association, & National Council on Measurement in Education [AERA, APA, & NCME], in press). Such information may include the purpose, nature, and anticipated use of the examination; who will have access to the information; associated limitations on privacy, confidentiality, and privilege including who is authorized to release or access the information contained in the forensic practitioner's records; the voluntary or involuntary nature of participation, including potential consequences of par-

ticipation or nonparticipation, if known; and, if the cost of the service is the responsibility of the examinee, the anticipated cost.

Guideline 6.03.01: Persons Not Ordered or Mandated to Undergo Examination

If the examinee is not ordered by the court to participate in a forensic examination, the forensic practitioner seeks his or her informed consent (EPPCC Standards 3.10, 9.03). If the examinee declines to proceed after being notified of the nature and purpose of the forensic examination, the forensic practitioner may consider postponing the examination, advising the examinee to contact his or her attorney, and notifying the retaining party about the examinee's unwillingness to proceed.

Guideline 6.03.02: Persons Ordered or Mandated to Undergo Examination or Treatment

If the examinee is ordered by the court to participate, the forensic practitioner can conduct the examination over the objection, and without the consent, of the examinee (EPPCC Standards 3.10, 9.03). If the examinee declines to proceed after being notified of the nature and purpose of the forensic examination, the forensic practitioner may consider a variety of options including postponing the examination, advising the examinee to contact his or her attorney, and notifying the retaining party about the examinee's unwillingness to proceed.

When an individual is ordered to undergo treatment but the goals of treatment are determined by a legal authority rather than the individual receiving services, the forensic practitioner informs the service recipient of the nature and purpose of treatment, and any limitations on confidentiality and privilege (EPPCC Standards 3.10, 10.01).

Guideline 6.03.03: Persons Lacking Capacity to Provide Informed Consent

Forensic practitioners appreciate that the very conditions that precipitate psychological examination of individuals involved in legal proceedings can impair their functioning in a variety of important ways, including their ability to understand and consent to the evaluation process.

For examinees adjudicated or presumed by law to lack the capacity to provide informed consent for the anticipated forensic service, the forensic practitioner nevertheless provides an appropriate explanation, seeks the examinee's assent, and obtains appropriate permission from a legally authorized person, as permitted or required by law (EPPCC Standards 3.10, 9.03).

For examinees whom the forensic practitioner has concluded lack capacity to provide informed consent to a proposed, non-court-ordered service, but who have not been adjudicated as lacking such capacity, the forensic practitioner strives to take reasonable steps to protect their rights and welfare (EPPCC Standard 3.10). In such cases, the forensic practitioner may consider suspending the proposed service or notifying the examinee's attorney or the retaining party.

Guideline 6.03.04: Evaluation of Persons Not Represented by Counsel

Because of the significant rights that may be at issue in a legal proceeding, forensic practitioners carefully consider the appropriateness of conducting a forensic evaluation of an individual who is not represented by counsel. Forensic practitioners may consider conducting such evaluations or delaying the evaluation so as to provide the examinee with the opportunity to consult with counsel.

Guideline 6.04: Communication With Collateral Sources of Information

Forensic practitioners disclose to potential collateral sources information that might reasonably be expected to inform their decisions about participating that may include, but may not be limited to, who has retained the forensic practitioner; the nature, purpose, and intended use of the examination or other procedure; the nature of and any limits on privacy, confidentiality, and privilege; and whether their participation is voluntary (EPPCC Standard 3.10).

Guideline 6.05: Communication in Research Contexts

When engaging in research or scholarly activities conducted as a service to a client in a legal proceeding, forensic practitioners attempt to clarify any anticipated use of the research or scholarly product, disclose their role in the resulting research or scholarly products, and obtain whatever consent or agreement is required.

In advance of any scientific study, forensic practitioners seek to negotiate with the client the circumstances under and manner in which the results may be made known to others. Forensic practitioners strive to balance the potentially competing rights and interests of the retaining party with the inappropriateness of suppressing data, for example, by agreeing to report the data without identifying the jurisdiction in which the study took place. Forensic practitioners represent the results of research in an accurate manner (EPPCC Standard 5.01).

7. Conflicts in Practice

In forensic psychology practice, conflicting responsibilities and demands may be encountered. When conflicts occur, forensic practitioners seek to make the conflict known to the relevant parties or agencies, and consider the rights and interests of the relevant parties or agencies in their attempts to resolve the conflict.

Guideline 7.01: Conflicts With Legal Authority

When their responsibilities conflict with law, regulations, or other governing legal authority, forensic practitioners make known their commitment to the EPPCC, and take steps to resolve the conflict. In situations in which the

EPPCC or the Guidelines are in conflict with the law, attempts to resolve the conflict are made in accordance with the EPPCC (EPPCC Standard 1.02).

When the conflict cannot be resolved by such means, forensic practitioners may adhere to the requirements of the law, regulations, or other governing legal authority, but only to the extent required and not in any way that violates a person's human rights (EPPCC Standard 1.03).

Forensic practitioners are encouraged to consider the appropriateness of complying with court orders when such compliance creates potential conflicts with professional standards of practice.

Guideline 7.02: Conflicts With Organizational Demands

When the demands of an organization with which they are affiliated or for whom they are working conflict with their professional responsibilities and obligations, forensic practitioners strive to clarify the nature of the conflict and, to the extent feasible, resolve the conflict in a way consistent with professional obligations and responsibilities (EPPCC Standard 1.03).

Guideline 7.03: Resolving Ethical Issues With Fellow Professionals

When an apparent or potential ethical violation has caused, or is likely to cause, substantial harm, forensic practitioners are encouraged to take action appropriate to the situation and consider a number of factors including the nature and the immediacy of the potential harm; applicable privacy, confidentiality, and privilege; how the rights of the relevant parties may be affected by a particular course of action; and any other legal or ethical obligations (EPPCC Standard 1.04). Steps to resolve perceived ethical conflicts may include, but are not limited to, obtaining the consultation of knowledgeable colleagues, obtaining the advice of independent counsel, and conferring directly with the client.

When forensic practitioners believe there may have been an ethical violation by another professional, an attempt is made to resolve the issue by bringing it to the attention of that individual, if that attempt does not violate any rights or privileges that may be involved, and if an informal resolution appears appropriate (EPPCC Standard 1.04). If this does not result in a satisfactory resolution, the forensic practitioner may have to take further action appropriate to the situation, including making a report to third parties of the perceived ethical violation (EPPCC Standard 1.05). In most instances, in order to minimize unforeseen risks to the party's rights in the legal matter, forensic practitioners consider consulting with the client before attempting to resolve a perceived ethical violation with another professional.

8. Privacy, Confidentiality, and Privilege

Forensic practitioners recognize their ethical obligations to maintain the confidentiality of information relating to a client or retaining party, except insofar as disclosure is consented to by the client or retaining party, or required or permitted by law (EPPCC Standard 4.01).

Guideline 8.01: Release of Information

Forensic practitioners are encouraged to recognize the importance of complying with properly noticed and served subpoenas or court orders directing release of information, or other legally proper consent from duly authorized persons, unless there is a legally valid reason to offer an objection. When in doubt about an appropriate response or course of action, forensic practitioners may seek assistance from the retaining client, retain and seek legal advice from their own attorney, or formally notify the drafter of the subpoena or order of their uncertainty.

Guideline 8.02: Access to Information

If requested, forensic practitioners seek to provide the retaining party access to, and a meaningful explanation of, all information that is in their records for the matter at hand, consistent with the relevant law, applicable codes of ethics and professional standards, and institutional rules and regulations. Forensic examinees typically are not provided access to the forensic practitioner's records without the consent of the retaining party. Access to records by anyone other than the retaining party is governed by legal process, usually subpoena or court order, or by explicit consent of the retaining party. Forensic practitioners may charge a reasonable fee for the costs associated with the storage, reproduction, review, and provision of records.

Guideline 8.03: Acquiring Collateral and Third Party Information

Forensic practitioners strive to access information or records from collateral sources with the consent of the relevant attorney or the relevant party, or when otherwise authorized by law or court order.

Guideline 8.04: Use of Case Materials in Teaching, Continuing Education, and Other Scholarly Activities

Forensic practitioners using case materials for purposes of teaching, training, or research strive to present such information in a fair, balanced, and respectful manner. They attempt to protect the privacy of persons by disguising the confidential, personally identifiable information of all persons and entities who would reasonably claim a privacy interest; using only those aspects of the case available in the public domain; or obtaining consent from the relevant clients, parties, participants, and organizations to use the materials for such purposes (EPPCC Standard 4.07; also see Guidelines 11.06 and 11.07 of these Guidelines).

9. Methods and Procedures

Guideline 9.01: Use of Appropriate Methods

Forensic practitioners strive to utilize appropriate methods and procedures in their work. When performing examinations, treatment, consultation, educational activities, or scholarly investigations, forensic practitioners seek to

maintain integrity by examining the issue or problem at hand from all reasonable perspectives and seek information that will differentially test plausible rival hypotheses.

Guideline 9.02: Use of Multiple Sources of Information

Forensic practitioners ordinarily avoid relying solely on one source of data, and corroborate important data whenever feasible (AERA, APA, & NCME, in press). When relying upon data that have not been corroborated, forensic practitioners seek to make known the uncorroborated status of the data, any associated strengths and limitations, and the reasons for relying upon the data.

Guideline 9.03: Opinions Regarding Persons Not Examined

Forensic practitioners recognize their obligations to only provide written or oral evidence about the psychological characteristics of particular individuals when they have sufficient information or data to form an adequate foundation for those opinions or to substantiate their findings (EPPCC Standard 9.01). Forensic practitioners seek to make reasonable efforts to obtain such information or data, and they document their efforts to obtain it. When it is not possible or feasible to examine individuals about whom they are offering an opinion, forensic practitioners strive to make clear the impact of such limitations on the reliability and validity of their professional products, opinions, or testimony.

When conducting a record review or providing consultation or supervision that does not warrant an individual examination, forensic practitioners seek to identify the sources of information on which they are basing their opinions and recommendations, including any substantial limitations to their opinions and recommendations.

10. Assessment

Guideline 10.01: Focus on Legally Relevant Factors

Forensic examiners seek to assist the trier of fact to understand evidence or determine a fact in issue, and they provide information that is most relevant to the psycholegal issue. In reports and testimony, forensic practitioners typically provide information about examinees' functional abilities, capacities, knowledge, and beliefs, and address their opinions and recommendations to the identified psycholegal issues (American Bar Association & American Psychological Assocation, 2008; Grisso, 1986, 2003; Heilbrun, Marczyk, DeMatteo, & Mack-Allen, 2007).

Forensic practitioners are encouraged to consider the problems that may arise by using a clinical diagnosis in some forensic contexts, and consider and qualify their opinions and testimony appropriately.

Guideline 10.02: Selection and Use of Assessment Procedures

Forensic practitioners use assessment procedures in the manner and for the purposes that are appropriate in light of the research on or evidence of their usefulness and proper application (EPPCC Standard 9.02; AERA, APA, & NCME, in press). This includes assessment techniques, interviews, tests, instruments, and other procedures and their administration, adaptation, scoring, and interpretation, including computerized scoring and interpretation systems.

Forensic practitioners use assessment instruments whose validity and reliability have been established for use with members of the population assessed. When such validity and reliability have not been established, forensic practitioners consider and describe the strengths and limitations of their findings. Forensic practitioners use assessment methods that are appropriate to an examinee's language preference and competence, unless the use of an alternative language is relevant to the assessment issues (EPPCC Standard 9.02).

Assessment in forensic contexts differs from assessment in therapeutic contexts in important ways that forensic practitioners strive to take into account when conducting forensic examinations. Forensic practitioners seek to consider the strengths and limitations of employing traditional assessment procedures in forensic examinations (AERA, APA, & NCME, in press). Given the stakes involved in forensic contexts, forensic practitioners strive to ensure the integrity and security of test materials and results (AERA, APA, & NCME, in press).

When the validity of an assessment technique has not been established in the forensic context or setting in which it is being used, the forensic practitioner seeks to describe the strengths and limitations of any test results and explain the extrapolation of these data to the forensic context. Because of the many differences between forensic and therapeutic contexts, forensic practitioners consider and seek to make known that some examination results may warrant substantially different interpretation when administered in forensic contexts (AERA, APA, & NCME, in press).

Forensic practitioners consider and seek to make known that forensic examination results can be affected by factors unique to, or differentially present in, forensic contexts including response style, voluntariness of participation, and situational stress associated with involvement in forensic or legal matters (AERA, APA, & NCME, in press).

Guideline 10.03: Appreciation of Individual Differences

When interpreting assessment results, forensic practitioners consider the purpose of the assessment as well as the various test factors, test-taking abilities, and other characteristics of the person being assessed, such as situational, personal, linguistic, and cultural differences that might affect their judgments or reduce the accuracy of their interpretations (EPPCC Standard 9.06). Forensic practitioners strive to identify any significant strengths and limitations of their procedures and interpretations.

Forensic practitioners are encouraged to consider how the assessment process may be impacted by any disability an examinee is experiencing, make accommodations as

possible, and consider such when interpreting and communicating the results of the assessment (APA, 2011d).

Guideline 10.04: Consideration of Assessment Settings

In order to maximize the validity of assessment results, forensic practitioners strive to conduct evaluations in settings that provide adequate comfort, safety, and privacy.

Guideline 10.05: Provision of Assessment Feedback

Forensic practitioners take reasonable steps to explain assessment results to the examinee or a designated representative in language they can understand (EPPCC Standard 9.10). In those circumstances in which communication about assessment results is precluded, the forensic practitioner explains this to the examinee in advance (EPPCC Standard 9.10).

Forensic practitioners seek to provide information about professional work in a manner consistent with professional and legal standards for the disclosure of test data or results, interpretation of data, and the factual bases for conclusions.

Guideline 10.06: Documentation and Compilation of Data Considered

Forensic practitioners are encouraged to recognize the importance of documenting all data they consider with enough detail and quality to allow for reasonable judicial scrutiny and adequate discovery by all parties. This documentation includes, but is not limited to, letters and consultations; notes, recordings, and transcriptions; assessment and test data, scoring reports and interpretations; and all other records in any form or medium that were created or exchanged in connection with a matter.

When contemplating third party observation or audio/video-recording of examinations, forensic practitioners strive to consider any law that may control such matters, the need for transparency and documentation, and the potential impact of observation or recording on the validity of the examination and test security (Committee on Psychological Tests and Assessment, American Psychological Association, 2007).

Guideline 10.07: Provision of Documentation

Pursuant to proper subpoenas or court orders, or other legally proper consent from authorized persons, forensic practitioners seek to make available all documentation described in Guideline 10.05, all financial records related to the matter, and any other records including reports (and draft reports if they have been provided to a party, attorney, or other entity for review), that might reasonably be related to the opinions to be expressed.

Guideline 10.08: Record Keeping

Forensic practitioners establish and maintain a system of record keeping and professional communication (EPPCC Standard 6.01; APA, 2007), and attend to relevant laws and rules. When indicated by the extent of the rights, liberties, and properties that may be at risk, the complexity of the case, the amount and legal significance of unique evidence in the care and control of the forensic practitioner, and the likelihood of future appeal, forensic practitioners strive to inform the retaining party of the limits of record keeping times. If requested to do so, forensic practitioners consider maintaining such records until notified that all appeals in the matter have been exhausted, or sending a copy of any unique components/aspects of the record in their care and control to the retaining party before destruction of the record.

11. Professional and Other Public Communications

Guideline 11.01: Accuracy, Fairness, and Avoidance of Deception

Forensic practitioners make reasonable efforts to ensure that the products of their services, as well as their own public statements and professional reports and testimony, are communicated in ways that promote understanding and avoid deception (EPPCC Standard 5.01).

When in their role as expert to the court or other tribunals, the role of forensic practitioners is to facilitate understanding of the evidence or dispute. Consistent with legal and ethical requirements, forensic practitioners do not distort or withhold relevant evidence or opinion in reports or testimony. When responding to discovery requests and providing sworn testimony, forensic practitioners strive to have readily available for inspection all data which they considered, regardless of whether the data supports their opinion, subject to and consistent with court order, relevant rules of evidence, test security issues, and professional standards (AERA, APA, & NCME, in press; Committee on Legal Issues, American Psychological Association, 2006; Bank & Packer, 2007; Golding, 1990).

When providing reports and other sworn statements or testimony in any form, forensic practitioners strive to present their conclusions, evidence, opinions, or other professional products in a fair manner. Forensic practitioners do not, by either commission or omission, participate in misrepresentation of their evidence, nor do they participate in partisan attempts to avoid, deny, or subvert the presentation of evidence contrary to their own position or opinion (EPPCC Standard 5.01). This does not preclude forensic practitioners from forcefully presenting the data and reasoning upon which a conclusion or professional product is based.

Guideline 11.02: Differentiating Observations, Inferences, and Conclusions

In their communications, forensic practitioners strive to distinguish observations, inferences, and conclusions. Forensic practitioners are encouraged to explain the relationship between their expert opinions and the legal issues and facts of the case at hand.

Guideline 11.03: Disclosing Sources of Information and Bases of Opinions

Forensic practitioners are encouraged to disclose all sources of information obtained in the course of their professional services, and to identify the source of each piece of information that was considered and relied upon in formulating a particular conclusion, opinion, or other professional product.

Guideline 11.04: Comprehensive and Accurate Presentation of Opinions in Reports and Testimony

Consistent with relevant law and rules of evidence, when providing professional reports and other sworn statements or testimony, forensic practitioners strive to offer a complete statement of all relevant opinions that they formed within the scope of their work on the case, the basis and reasoning underlying the opinions, the salient data or other information that was considered in forming the opinions, and an indication of any additional evidence that may be used in support of the opinions to be offered. The specific substance of forensic reports is determined by the type of psycholegal issue at hand as well as relevant laws or rules in the jurisdiction in which the work is completed.

Forensic practitioners are encouraged to limit discussion of background information that does not bear directly upon the legal purpose of the examination or consultation. Forensic practitioners avoid offering information that is irrelevant and that does not provide a substantial basis of support for their opinions, except when required by law (EPPCC Standard 4.04).

Guideline 11.05: Commenting Upon Other Professionals and Participants in Legal Proceedings

When evaluating or commenting upon the work or qualifications of other professionals involved in legal proceedings, forensic practitioners seek to represent their disagreements in a professional and respectful tone, and base them on a fair examination of the data, theories, standards, and opinions of the other expert or party.

When describing or commenting upon clients, examinees, or other participants in legal proceedings, forensic practitioners strive to do so in a fair and impartial manner.

Forensic practitioners strive to report the representations, opinions, and statements of clients, examinees, or other participants in a fair and impartial manner.

Guideline 11.06: Out of Court Statements

Ordinarily, forensic practitioners seek to avoid making detailed public (out-of-court) statements about legal proceedings in which they have been involved. However, sometimes public statements may serve important goals such as educating the public about the role of forensic practitioners in the legal system, the appropriate practice of forensic psychology, and psychological and legal issues that are relevant to the matter at hand. When making public statements, forensic practitioners refrain from releasing private, confidential, or privileged information, and attempt to protect persons from harm, misuse, or misrepresentation as a result of their statements (EPPCC Standard 4.05).

Guideline 11.07: Commenting Upon Legal Proceedings

Forensic practitioners strive to address particular legal proceedings in publications or communications only to the extent that the information relied upon is part of a public record, or when consent for that use has been properly obtained from any party holding any relevant privilege (also see Guideline 8.04).

When offering public statements about specific cases in which they have not been involved, forensic practitioners offer opinions for which there is sufficient information or data and make clear the limitations of their statements and opinions resulting from having had no direct knowledge of or involvement with the case (EPPCC Standard 9.01).

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Appendix A
Revision Process of the Guidelines

This revision of the Guidelines was coordinated by the Committee for the Revision of the Specialty Guidelines for Forensic Psychology ("the Revisions Committee"), which was established by the American Academy of Forensic Psychology and the American Psychology–Law Society (Division 41 of the American Psychological Association [APA]) in 2002 and which operated through 2011. This committee consisted of two representatives from each organization (Solomon Fulero, PhD, JD; Stephen Golding, PhD, ABPP; Lisa Piechowski, PhD, ABPP; Christina Studebaker, PhD), a chairperson (Randy Otto, PhD, ABPP), and a liaison from Division 42 (Psychologists in Independent Practice) of APA (Jeffrey Younggren, PhD, ABPP).

This document was revised in accordance with APA Rule 30.08 and the APA policy document "Criteria for Practice Guideline Development and Evaluation" (APA, 2002). The Revisions Committee posted announcements regarding the revision process to relevant electronic discussion lists and professional publications (i.e., the Psylaw-L e-mail listserv of the American Psychology–Law Society, the American Academy of Forensic Psychology listserv, the American Psychology–Law Society Newsletter). In addition, an electronic discussion list devoted solely to issues concerning revision of the Guidelines was operated between December 2002 and July 2007, followed by establishment of an e-mail address in February 2008 (sgfp@yahoo.com). Individuals were invited to provide input and commentary on the existing Guidelines and proposed revisions via these means. In addition, two public meetings were held throughout the revision process at biennial meetings of the American Psychology–Law Society.

Upon development of a draft that the Revisions Committee deemed suitable, the revised Guidelines were submitted for review to the Executive Committee of the American Psychology–Law Society (Division 41 of APA) and the American Board of Forensic Psychology. Once the revised Guidelines were approved by these two organizations, they were submitted to APA for review, commentary, and acceptance, consistent with APA's "Criteria for Practice Guideline Development and Evaluation" (APA, 2002) and APA Rule 30-8. They were subsequently revised by the Revisions Committee and were adopted by the APA Council of Representatives on August 3, 2011.

(*Appendices continue*)

Appendix B
Definitions and Terminology

For the purposes of these Guidelines:

Appropriate, when used in relation to conduct by a forensic practitioner means that, according to the prevailing professional judgment of competent forensic practitioners, the conduct is apt and pertinent and is considered befitting, suitable, and proper for a particular person, place, condition, or function. ***Inappropriate*** means that, according to the prevailing professional judgment of competent forensic practitioners, the conduct is not suitable, desirable, or properly timed for a particular person, occasion, or purpose; and may also denote improper conduct, improprieties, or conduct that is discrepant for the circumstances.

Agreement refers to the objective and mutual understanding between the forensic practitioner and the person or persons seeking the professional service and/or agreeing to participate in the service. See also Assent, Consent, and Informed Consent.

Assent refers to the agreement, approval, or permission, especially regarding verbal or nonverbal conduct, that is reasonably intended and interpreted as expressing willingness, even in the absence of unmistakable consent. Forensic practitioners attempt to secure assent when consent and informed consent cannot be obtained or when, because of mental state, the examinee may not be able to consent.

Consent refers to agreement, approval, or permission as to some act or purpose.

Client refers to the attorney, law firm, court, agency, entity, party, or other person who has retained, and who has a contractual relationship with, the forensic practitioner to provide services.

Conflict of Interest refers to a situation or circumstance in which the forensic practitioner's objectivity, impartiality, or judgment may be jeopardized due to a relationship, financial, or any other interest that would reasonably be expected to substantially affect a forensic practitioner's professional judgment, impartiality, or decision making.

Decision Maker refers to the person or entity with the authority to make a judicial decision, agency determination, arbitration award, or other contractual determination after consideration of the facts and the law.

Examinee refers to a person who is the subject of a forensic examination for the purpose of informing a decision maker or attorney about the psychological functioning of that examinee.

Forensic Examiner refers to a psychologist who examines the psychological condition of a person whose psychological condition is in controversy or at issue.

Forensic Practice refers to the application of the scientific, technical, or specialized knowledge of psychology to the law and the use of that knowledge to assist in resolving legal, contractual, and administrative disputes.

Forensic Practitioner refers to a psychologist when engaged in forensic practice.

Forensic Psychology refers to all forensic practice by any psychologist working within any subdiscipline of psychology (e.g., clinical, developmental, social, cognitive).

Informed Consent denotes the knowledgeable, voluntary, and competent agreement by a person to a proposed course of conduct after the forensic practitioner has communicated adequate information and explanation about the material risks and benefits of, and reasonably available alternatives to, the proposed course of conduct.

Legal Representative refers to a person who has the legal authority to act on behalf of another.

Party refers to a person or entity named in litigation, or who is involved in, or is witness to, an activity or relationship that may be reasonably anticipated to result in litigation.

Reasonable or ***Reasonably***, when used in relation to conduct by a forensic practitioner, denotes the conduct of a prudent and competent forensic practitioner who is engaged in similar activities in similar circumstances.

Record or ***Written Record*** refers to all notes, records, documents, memorializations, and recordings of considerations and communications, be they in any form or on any media, tangible, electronic, handwritten, or mechanical, that are contained in, or are specifically related to, the forensic matter in question or the forensic service provided.

Retaining Party refers to the attorney, law firm, court, agency, entity, party, or other person who has retained, and who has a contractual relationship with, the forensic practitioner to provide services.

Tribunal denotes a court or an arbitrator in an arbitration proceeding, or a legislative body, administrative agency, or other body acting in an adjudicative capacity. A legislative body, administrative agency, or other body acts in an adjudicative capacity when a neutral official, after the presentation of legal argument or evidence by a party or parties, renders a judgment directly affecting a party's interests in a particular matter.

Trier of Fact refers to a court or an arbitrator in an arbitration proceeding, or a legislative body, administrative agency, or other body acting in an adjudicative capacity. A legislative body, administrative agency, or other body acts in an adjudicative capacity when a neutral official, after the presentation of legal argument or evidence by a party or parties, renders a judgment directly affecting a party's interests in a particular matter.

STUDENT NOTES

HIGH-CONFLICT DIVORCE: A FORM OF CHILD NEGLECT

Alexa N. Joyce

In high-conflict divorce cases, the emotional toll on the family unit is unquestionably destructive. While the physical and mental health of the children should be the primary focus, the emotional turmoil of a high-conflict divorce often moves the focus away from the children as parents struggle emotionally and financially. Although the best interests of the children are always in the judicial purview, the repeated, lengthy, and hostile litigation process often associated with high-conflict dissolution has lasting effects on the physical and mental health of children, similar to those associated with physical abuse and neglect. Child Protective Services (CPS) must step in and protect the emotional well-being of children during high-conflict divorce cases.

Key Points for the Family Law Community:

- High-conflict divorce is detrimental to the entire family unit and often causes emotional and psychological harm to the children.
- Children entrenched in their parents' high-conflict divorce experience emotional neglect.
- Emotional neglect is an under-recognized form of child neglect that warrants state intervention through Child Protective Services.
- Emotional neglect is underreported and often unrecognizable to the untrained eye.
- Child Protective Services must be responsible for investigating possible emotional neglect in high-conflict divorce cases and connecting families with appropriate therapeutic interventions.
- An attorney for the child must be appointed where Child Protective Services is forced to petition the court for compliance with therapeutic intervention or services.

Keywords: *Child Abuse; Child Neglect; Child Protective Services; Divorce; Emotional Harm; Emotional Neglect; High Conflict; Mental Health; Parental Conflict; Social Work Perspective; and Therapeutic Intervention.*

I. INTRODUCTION

Everyone in the courtroom was crying—everyone but the parents of the two young children. The case began as a typical divorce. After three years of expensive, lengthy, and draining litigation, the case was finally set for trial. What made this case unique, however, was the presence of the New Jersey Division of Child Protection and Permanency (DCPP)[1] and a law guardian[2] appointed to represent the two minor children. A DCPP case was opened when the parents began making baseless allegations of sexual abuse and child neglect. Although the allegations were unfounded, the case remained open because the father continued to make accusations of physical abuse and neglect against the mother on a biweekly basis. The caseworker was the only adult willing to supervise and facilitate visitation between the brothers. He understood how precious their visits were together and the importance of sibling bonding to the emotional and developmental health of the boys. Additionally, the court-appointed law guardian was not comfortable being removed from the case and leaving the two minor children with no voice or representation.

The mother in this case remained in the marital home with the younger child, Michael, age six.[3] The father, upon being "evicted" from the mother's rental home, decided to move to the farthest

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FAMILY COURT REVIEW, Vol. 54 No. 4, October 2016 642–656

corner of New Jersey, almost three hours away. The father took the older son, Sean, age ten, with him to his new home.[4] The parents pitted the child in their custody against the noncustodial parent. On the first day of trial, Michael and Sean were both individually interviewed by the judge in chambers while the rest of the courtroom listened to their heartbreaking testimony. It was clear to everyone in the courtroom that the older child was brainwashed by his father to believe the most terrible and disgusting, albeit baseless, facts about his mother. On the other hand, the younger son was completely terrified and wary of his father. What the two brothers truly wanted was to be together.

During his interview, Michael began to cry numerous times. Through his tears, Michael raised his voice and began shouting: "No, my parents can't agree about anything. NOTHING. I don't get it. I don't get why. But I don't care. I just want to be with my brother. I don't care if we have to be with my mom or my dad. I don't care about seeing either of them, I just want to be with my brother." In that moment, it was clear why the DCPP case was never closed. The children needed protection, a voice, representation, and supervision of their emotional and physical health.

Upon observation of Michael and Sean, it was clear that they not only loved and cherished their sibling relationship, but they also enjoyed more trust and respect in their relationships with their caseworker and attorney than with their own parents. While their parents continued to bicker during the lunch break, the caseworker volunteered to take the children to lunch and to the park to facilitate visitation. The parents could not agree on anything regarding visitation for the children. The caseworker and law guardian were the only two adults willing to stand up for the children and to help them foster their sibling relationship. At the end of the second day of trial, the law guardian insisted on sibling visitation[5] during the pendency of the trial. Both attorneys for the parents immediately stood up to contest this request on behalf of their clients. It was clear the parents no longer had the ability to recognize the best interests of their children as the highest priority in this case. Their priority was winning and making sure that the other side suffered.

"High-conflict divorce" will be used throughout this Note to refer to cases associated with extreme lack of trust between parties, elevated levels of anger, and willingness to engage in repetitive litigation[6] as well as to parental relationships marked by fear, projection of blame, refusal to cooperate or communicate, allegations of abuse, and sabotage of parent–child relationships.[7] Only about one tenth of divorcing couples experience repeated litigation and proceed to trial before coming to a final stipulation.[8] This repeated litigation, overt hostility, anger, and tension carries over into the daily lives of children who are victimized by their parents' high-conflict divorce.[9]

The developmental, emotional, and physical health of children involved in these divorces are dramatically affected.[10] The inability of the parties to settle disputes creates high levels of anxiety and defensiveness within the family unit. Additionally, high-conflict divorce decreases parenting competence and reduces the prioritization of the best interests of the children.[11] For children involved in high-conflict divorce, coping strategies, adjustment, academic achievement, self-esteem, psychological distress, depression, delinquency, substance abuse, sexual precocity, and suicidal behaviors may color their future long after dissolution of their parents' marriage.[12] The unintended victims of high-conflict divorce must be adequately monitored.

Parents involved in high-conflict divorce are often not emotionally stable enough to ensure the best interests of the children are protected throughout the litigation process.[13] They often evaluate their decisions from a place of anger, jealousy, and self-centeredness. While some jurisdictions do provide mechanisms to protect the child in certain situations, including the appointment of a guardian ad litem[14] or an attorney for the child,[15] the rights and needs of children must be statutorily protected nationwide.[16] As previously mentioned, high-conflict divorces represent a relatively small percentage of all marital dissolutions in the United States.[17] However, in the last two decades, nearly two million children were caught in the crossfire of these contentious dissolutions.[18] As a matter of public policy, there is a need for a more regulated and consistent protection of these children.[19]

This Note proposes the implementation of a national, statutory two-pronged approach to the dissolution of marriage in high-conflict cases. The statutory provision will require: (1) referrals to CPS by the family or matrimonial court judge presiding over any case deemed to be high conflict and/or involved

in continuous litigation for more than eighteen months and (2) the appointment of an attorney for the child, upon a finding of emotional neglect and noncompliance with recommended CPS services.

In Part II, this Note will discuss the effects that high-conflict divorce has on children and parents, both during and after the dissolution process. Part III will discuss the effects of physical abuse and neglect on children as well as the traditional role of CPS. Thereafter, this section will describe the reluctance of CPS to provide services for emotionally neglected children and compare the effects of various types of abuse and neglect on children. Part III will discuss the need for the emotional neglect of children to be more thoroughly protected by CPS as it relates to high-conflict divorce. Part IV will discuss how CPS can ensure the emotional needs of children are addressed during high-conflict dissolution. This section will argue for a uniform national statute mandating CPS investigations and the appointment of an attorney for the child where there is a substantiated finding of emotional neglect. Part V will address the risks and benefits of creating a separate statute for the welfare of children involved in high-conflict divorce cases as it relates to children, families, and social policy. Part VI will reiterate the importance of protecting the emotional well-being of children involved in high-conflict dissolution cases through the implementation of a uniform statute.

II. THE EFFECTS OF HIGH-CONFLICT DIVORCE ON CHILDREN AND FAMILIES

A. WHAT IS A HIGH-CONFLICT DIVORCE?

High-conflict divorce is illustrated by a consistent desire to litigate, extreme hostility, and lack of trust between parties that may emanate from dysfunctional marital relationships, mental health disorders, criminal backgrounds, substance abuse, and/or allegations of domestic violence or child abuse.[20] Characteristics of high-conflict divorce include: repetitive disputes over parenting practices, physical threats, and actual violence.[21] Allegations of adultery or instances where one partner abandons the marriage while the other partner is still in love often lead to elevated levels of hostility, anger, and distrust.[22] The dynamics of the relationship, both pre- and postseparation as well as the personality traits and mental health concerns of the couple may thrust a family into a heated, hostile, and strongly contentious divorce.

Some commentators argue that the adversarial system of a matrimonial proceeding exacerbates conflict in contentious divorce proceedings.[23] While partners in a failing relationship are experiencing hostility, their attorneys who zealously represent their clients may only worsen the problem.[24] The desire of both sides to "win" the divorce can perpetuate conflict, litigation, and feelings of hostility.[25] Linda D. Elrod, a distinguished family law professor at Washburn University School of Law, argues that "the win/lose framework [of litigation] encourages parents to find fault with each other rather than to cooperate."[26] In an attempt to enhance their client's position, attorneys often make "extreme demands to increase the bargaining advantage [which] only escalate[s] conflict."[27] Repeated litigation drains both parties of financial and emotional resources.[28] This contributes to increased levels of stress and anxiety that often present as anger, aggression, and hatred.

B. MAKING THE DECISION TO END A MARRIAGE CONSIDERING THE BEST INTERESTS OF THE CHILDREN

The interpersonal and interfamilial dysfunction that often leads to high-conflict divorce disturbs the entire familial unit.[29] These disruptions often lead to behavioral and emotional issues for children both during and after the dissolution.[30] Regardless of whether a divorce is considered high conflict, it is nonetheless a traumatic experience for children as family finances diminish, one or both parents leave the marital home, and parents become less likely to "meaningfully and constructively" attend to their children's needs.[31]

Commentators and social scientists have long debated whether or not it is more appropriate for parents to stay together for the sake of the children or to end the marriage.[32] While conservative viewpoints endorse the notion that divorce is always bad for children, social science research indicates that "children who are exposed to serious conflict in their parents' marriage are better off when conflict is reduced by divorce."[33] However, high-conflict marriages are often precursors to high-conflict divorces. The marital conflict generally carries over into the divorce and accentuates the effects of the dysfunctional parental relationship on the emotional well-being of the children.[34]

C. THE EMOTIONAL EFFECTS OF HIGH-CONFLICT PARENTAL RELATIONSHIPS ON CHILDREN

While acknowledging that ending a high-conflict marriage is generally beneficial to children, social science further suggests that high levels of parental conflict during the marriage often carry into the dissolution process and continue to harm the emotional well-being of children.[35] Symptoms such as conduct disorders, antisocial behaviors, difficulty with peers and authority figures, depression, and academic problems are found more frequently in children from high-conflict marriages as opposed to children from low-conflict marriages.[36] In general, children of divorce are more aggressive and antisocial.[37] Children who experience high-conflict marriage and divorce are more prone to depression and other mental health issues as young adults.[38] The more frequent and continuous the parental conflict, the more likely it is to have a negative impact on the children.[39] Parental conflict that is centered on the children, such as custody, parenting time, visitation, or support, is most troublesome and causes children to "express more self-blame, shame, and fear of being drawn into the conflict."[40]

D. HOW HIGH-CONFLICT DIVORCE AFFECTS CHILDREN SOCIALLY

Parents are the primary exemplars for children on how to handle conflict, compromise, and resolution. Children often mirror their parents' behavior, viewing them as role models, mentors, and teachers of life skills, coping mechanisms, and communication techniques.[41] Because parents involved in high-conflict marriages and divorce are commonly lacking in these skills, they frequently pass these deficiencies on to their children.[42] Because these skills are often inadequately modeled in families with high levels of parental conflict, children often struggle with social interaction.[43] They become overly angry, impulsive, or violent whenever they experience conflict.[44] Healthy modes of expression are generally absent in high-conflict relationships, which causes children to exhibit frequent and extreme anxiety based on their inability to communicate.[45]

Additionally, parents involved in high-conflict marriage and divorce are more likely to use drugs or alcohol.[46] Consequently, their children are more prone to alcohol, cigarette, and marijuana experimentation than children from intact, low-conflict families.[47] Children whose parents divorce are more likely to experience unwed pregnancies, earlier marriages, weaker marital relationships, increased incidences of divorce, and lower socioeconomic status.[48]

E. THE EFFECTS OF HIGH-CONFLICT DIVORCE ON PARENT–CHILD RELATIONSHIPS

The presence of high conflict during marriage and throughout the dissolution process "undermines the quality of parenting" and parent–child relationships.[49] Conflicting spouses often undermine consistent parenting techniques. Fathers tend to shrink away from their role as disciplinarians or mentors whether it be willfully or by pressure from the mother.[50] This may decrease the quality of parent–child interactions and cause children to feel rejected.[51] The disruption of parenting and the use of contradicting parenting methods often lead to significant gaps in supervision.[52] Children in search of stability and recognition are therefore more likely to experiment with substance use as they migrate

toward friends.[53] Additionally, due to lack of supervision, children of divorce often experience lower levels of academic achievement.[54]

Parents in high-conflict marriages are often depressed.[55] This has a negative impact on the children as they model their parents' behavior.[56] Social science suggests that adjustment of the custodial parent postdivorce is the "best predictor of child adjustment."[57] Continued conflict between parents and parental emotional distress make it difficult for the child to adjust to the divorce, particularly when the parent–child relationship is strained.[58] Children often exhibit less affection and contact and are less likely to care for their parents as they age.[59]

F. HOW THE FINANCIAL CONSEQUENCES OF HIGH-CONFLICT DIVORCE AFFECT CHILDREN

Throughout the divorce process, a substantial amount of family resources are used for legal fees, child care, and reorganization of assets.[60] Often families must adjust to supporting two households instead of one.[61] The entire family suffers from a "substantial decline in standard of living," causing the children to experience a sense of financial insecurity.[62] As described by Joan B. Kelly, a psychologist dedicated to researching the impact of divorce on families, "it is estimated the economic problems of divorced households account for as much as half of the adjustment problems seen in [. . .] children."[63] The primary lingering financial effect for children from high-conflict divorce is less educational success and career options based on lack of adequate financial support.[64]

III. STATE INTERVENTION IN CHILD ABUSE AND NEGLECT CASES

A. THE EMOTIONAL EFFECTS OF PHYSICAL ABUSE AND NEGLECT ON CHILDREN

Physical child abuse and neglect are major public health issues.[65] Physically abused children often exhibit: poor ego development, anxiety, social detachment, aggression, and self-destructive behavior.[66] Abuse and neglect often damage child development and intensify antisocial behaviors.[67] Children often have intellectual deficits, underachieve academically, and have high rates of maladjustment.[68] The likelihood of physical abuse and neglect and the perpetuation of its harmful effects on children are often aggravated when parents are struggling with their own mental health or substance abuse issues or when the home environment is unstable.[69] Abused and neglected children typically do not have consistent or affectionate parental guidance, which causes lasting developmental, emotional, and social impediments.[70]

Physical abuse and neglect are easily identifiable by social workers, teachers, and lay people.[71] According to social work writer, Kieran O'Hagan, most agencies that deal with child abuse and neglect are "preoccupied with physical or sexual abuse to the exclusion of any other potential area of abuse."[72] Physical abuse and neglect is often easiest to prove because it is readily identifiable to the untrained eye.[73] Anyone can identify with ease a child who has bruises or who does not have appropriate clothing.[74] Therefore the primary focus of state intervention through its *parens patriae* power is the physical abuse and neglect of children.[75]

B. THE DEVELOPMENT OF STATE INTERVENTION IN PHYSICAL ABUSE AND NEGLECT CASES

In the 1960s and 1970s, states began to recognize the need for specialized investigations of allegations of child abuse and neglect.[76] By 1974, the Child Abuse Protection and Treatment Act (CAPTA) facilitated the rapid creation of CPS agencies nationwide.[77] In accordance with mandatory reporting statutes, most CPS agencies created "highly publicized 'hot lines'" to allow the public to make anonymous reports of abuse.[78] It is arguable that the majority of reports made to CPS would not be made

without mandatory reporting laws and the development of media campaigns calling attention to the importance of protecting children from physical abuse and neglect.[79]

Generally, when an individual calls the hotline, they speak with a trained caseworker from CPS.[80] If the caseworker finds that a child may be at risk, an investigator from CPS will investigate the allegations, generally within twenty-four hours of the report being made.[81] Although the process for investigations and the implementation of services varies by state, all CPS agencies perform similar functions:[82] investigate families and determine the best way to remedy their situation.[83] Working from a social work perspective, CPS helps families decide if mental health or social service programs would be beneficial in remedying substantiated cases of abuse or neglect.[84] Often parents are willing to work with CPS to remedy abuse and neglect, and court intervention is not necessary.[85] Ordinarily, the goal for most CPS agencies is to work toward resolving concerns using therapeutic intervention.[86] However, family court intervention is necessary when CPS recommends placing a child outside of the home or when a family is not cooperative.[87] Criminal prosecution is less common and depends on the severity and type of abuse or neglect.[88]

C. WHAT IS EMOTIONAL NEGLECT?

Emotional neglect is a form of neglect that lawyers, judges, and parents may not easily understand or acknowledge.[89] It is a common, yet underdocumented, form of neglect that is hard to identify, define, and prove.[90] Although emotional neglect often does not encompass any clear intent to cause harm to the child, it inevitably can cause physical, social, educational, and emotional impediments.[91] Emotional neglect is harmful to child development and its consequences often carry into adult life.[92] Emotional neglect has strong correlations with negative long-term psychological functioning, including "internalizing and externalizing behaviors, social impairment, low self-esteem, suicidal behavior, psychiatric diagnoses, and hospitalizations."[93]

Parental unavailability, unresponsiveness, and preoccupation with the parent's own personal mental health and substance use issues often lead to emotional neglect.[94] Where parents are unable to respond to the emotional needs of their children, children often feel responsible for filling the psychological voids created by their parents.[95] Continuous hostility, denigration, rejection, and/or exposure to traumatic life events often lead to emotional neglect.[96]

D. EMOTIONAL EFFECTS OF HIGH-CONFLICT DIVORCE VERSUS PHYSICAL ABUSE AND NEGLECT

High-conflict divorce often involves the emotional neglect of children. Witnessing interparental conflict is one of the most stressful life events for children.[97] Emotional neglect results when parents are preoccupied with their own financial, social, and emotional concerns.[98] High-conflict divorce is generally a traumatic life experience for a child that unquestionably exposes them to various risk factors of emotional neglect.[99] During divorce, children experience and must cope with drastic shifts in their living and financial situations. Their parents are often unavailable to provide emotional support during these stressful times, because they are engrossed with their own anxieties and/or lack productive coping mechanisms.[100]

Children of high-conflict divorce experience emotional effects similar to those experienced by children who are victimized by physical abuse and/or neglect.[101] Children who witness high-conflict parental dissolution similarly exhibit depression, antisocial behaviors, conduct disorders, low academic achievement, and problems with authority.[102] High-conflict divorce is a form of emotional neglect, and children should be afforded the same state protection provided to physically abused and neglected children.

E. WHY CPS INTERVENTION FOR EMOTIONAL NEGLECT IS RARE, IF NOT NONEXISTENT

Even though CPS workers are under a legal, moral, and professional obligation to recognize and understand emotional and psychological abuse, agencies often require workers to identify evidence of physical abuse or neglect before they can open cases.[103] Emotional neglect cases are rarely opened by CPS and are even less likely to be brought to the attention of a family court judge.[104] In general, the emotional health of children is only examined in conjunction with physical abuse and neglect, or intervening to ensure the mental health of a child is protected as it pertains to the effects of physical abuse.[105]

Emotional neglect ought to warrant the same state intervention as physical abuse and neglect. The state has parens patriae power to protect children from abuse and neglect at the hands of parents, guardians, or primary caregivers.[106] Read plainly, this power should require the state to intervene to protect children from emotional harm unrelated to physical abuse or neglect.[107] Courts pay very little attention to the stand-alone emotional needs of children, because the term "emotional health" is less understood by people outside of the mental health field.[108]

Therefore, CPS caseworkers must be responsible for identifying the emotional neglect of children.[109] Children are often at risk for emotional neglect when parents are preoccupied with their own mental health, substance use, or financial difficulties.[110] Often, parents are unable to identify emotional or psychological concerns and/or are unaware of interventions that are available.[111] Emotional neglect must be reported to CPS by schools, doctors, and social services.[112] It is necessary for trained caseworkers, operating from a social work perspective, to investigate, identify, and provide services to remedy potential emotional neglect.[113]

IV. MANDATORY STATE INTERVENTION IN HIGH-CONFLICT DIVORCE

A. THE SOLUTION

Investigations by CPS should be statutorily mandated in high-conflict divorce cases. The number of divorce cases characterized as high conflict is relatively low.[114] As conflict and litigation continues, even after a judgment of divorce is entered, parents in high-conflict cases deplete financial resources and continue to expose children to trauma.[115] Although high-conflict divorce cases are a breeding ground for the emotional neglect of children, these cases are generally not pursued by CPS and are rarely brought to the attention of the family court.[116]

While it is undisputed that the states' parens patriae power is intended to protect children from abuse and neglect, there is currently no universal definition.[117] The Child Abuse Prevention and Treatment Act includes in its definition of abuse and neglect, "any recent act or failure to act on the part of a parent or caretaker which results in [. . .] serious [. . .] emotional harm."[118] State intervention for emotional neglect should be required in accordance with the parens patriae power.

In high-conflict divorce cases, parents are often unable to recognize the unintended infliction of emotional neglect on their children, as they are preoccupied with their own issues and repeated litigation.[119] Because some matrimonial judges and lawyers may be ill equipped to acknowledge the stand-alone effects of the emotional neglect of children, it is imperative that CPS intervene on behalf of the children to connect the family with appropriate therapeutic interventions.[120] A federal statute should be adopted mandating state CPS agencies to investigate the emotional well-being of children where parents have been involved in high-conflict litigation for more than eighteen months. Upon a finding of emotional neglect, CPS shall intervene to implement appropriate services or therapeutic intervention.

B. HOW EMOTIONAL NEGLECT SHOULD BE UNIVERSALLY DEFINED

An emotionally neglected child is one whose parent, guardian, or primary caregiver either intentionally or unintentionally exposes the child to repeated traumatic situations, including but not

limited to extreme interparental conflict, emotional unavailability, or constant personal preoccupation.[121] In order to appropriately deem a child emotionally neglected, it is necessary for a mental health professional to evaluate the child.[122] Any child experiencing interparental conflict, including high-conflict divorce, for more than eighteen months is at risk for emotional neglect.[123] The presence of repeated, contentious, and lengthy litigation as well as intense levels of mistrust and hatred between parties is often unobservable to the untrained eye.[124] Therefore, after the eighteenth month of litigation, cases involving children should automatically be referred to CPS for a trained caseworker to investigate the need for services.

C. THE PROCEDURE FOR SUGGESTED STATE INTERVENTION

Similar to screening protocols for traditional physical abuse and neglect cases, trained caseworkers shall be responsible for meeting with children to determine whether they are at a heightened risk for emotional neglect.[125] Although unrecognizable to the untrained eye, emotional neglect is relatively easy for trained mental health professionals to identify.[126] A caseworker will determine the presence and severity of a number of factors to decide whether intervention and referral to mental health services is necessary by meeting with the children, parents, and other interested parties. The caseworker will examine: parental preoccupation with personal stressors[127]; the presence of conduct disorders, antisocial behaviors, difficulty with peers/authority figures, depression, academic problems, or anxieties in children[128]; whether parental conflict is predominantly centered around child-rearing issues[129]; and the level of parent–child affection and contact.[130] Caseworkers will use their professional judgment to determine whether a CPS case should be opened to provide services on the basis of emotional neglect.[131]

If a case is opened, CPS will work with the family to create an intervention plan to protect the emotional well-being of the children. The caseworker will connect the family with appropriate therapeutic services.[132] It is not likely a criminal or civil case will be opened against parents, except under extreme circumstances or where parents refuse to comply with the plan for therapeutic intervention.[133] Typically, parents will be willing to comply as they may have simply been unaware that their children's emotional needs were not being met.[134] If parents are noncompliant, CPS may petition the judge presiding over the matrimonial matter to order compliance.[135] If the court becomes involved, an attorney for the child shall be appointed.[136]

A pilot program should be implemented in each state prior to the adoption of a statute. It is unquestionable that high-conflict divorce generally leads to the emotional neglect of children based on the very nature of elevated levels of familial conflict and stress. Children involved in high-conflict divorce, nationwide, who are the victims of emotional neglect, must be afforded the same protection of state intervention as are children in physical abuse and neglect cases who suffer comparable emotional hardships.[137]

V. COSTS AND BENEFITS

A. HOW THE SOLUTION WILL PROTECT CHILDREN FROM A SOCIAL WORK PERSPECTIVE

The vast majority of emotional neglect cases are currently being ignored.[138] Although domestic violence and substance use certainly may be present during high-conflict dissolution, families do not generally exhibit any overt characteristics of physical abuse or neglect.[139] Instead, continuous litigation and conflicting parenting practices color the family dynamic, leaving children without proper emotional guidance.[140] High-conflict divorce is one of the strongest predictors of poor outcomes for children.[141] Mandatory intervention by CPS is only suggested in high-conflict cases, a disproportionately small number of divorce cases nationwide.[142] Most children and families are able to endure dissolution of a marriage without any long-lasting emotional harm, however, children

cannot survive divorce unharmed where there is "prolonged, chronic, hostility between parents."[143] In high-conflict situations, children are often left to "pay the price of their parents' stormy court battles."[144] It is nearly impossible for children involved in high-conflict divorce to escape from emotional harm.[145] CPS must be involved to ensure children receive adequate services, at least during the pendency of litigation.

Intervention would ensure parents are educated about and aware of the emotional harm they are inflicting on their children. While this may not expedite a faster resolution, parents may at least be made aware of the harm their contentious litigation is imposing on their children. CPS can work with a family to create an intervention plan to help them locate financial and therapeutic resources. Assuming the parents are receptive, no further action would be required either through the court or law enforcement absent a finding of physical abuse or neglect.

B. DISTINGUISHING EMOTIONAL NEGLECT FROM ABUSE AND THE EFFECTS OF THE SOLUTION ON PARENTS

High-conflict divorce or emotional neglect must be distinguished from abuse. Under the recommended statute, parents will not be held criminally liable for emotional neglect. Currently, there appears to be a recurrent disconnect within CPS agencies, as workers attempt to protect children without labeling or blaming caregivers.[146] This has led to inadequate protection for children against emotional neglect.[147] The number of children who are emotionally neglected and would benefit from the support and protection of CPS is seriously underestimated.[148] State intervention is necessary, but must be structured so as to protect the family unit from unnecessary social or financial destruction. The term neglect connotes the presence of poverty or interfamilial issues as opposed to serious criminal behavior indicated by the term abuse.[149] The argument that CPS should intervene is based on the inability of laypersons to identify emotional harm, parental fixation with personal turmoil, and the need to protect children, not the criminal fault of the parents.[150]

Only where a family is noncompliant will court intervention be necessary. The judge presiding over the matrimonial matter should be responsible for implementing intervention plans upon noncompliance. Unless, upon investigation, the caseworker finds physical abuse and/or neglect, the standards, protocol, and consequences for a finding of emotional neglect in a high-conflict divorce case will be much less severe and only operate to call attention to issues and employ therapeutic intervention. Where CPS petitions the court for implementation of a service plan, an attorney for the child must be appointed to ensure the wishes of the child are reflected on the record.[151]

C. WHAT ARE THE COSTS FOR CPS AND THE COURT SYSTEM?

Establishing a new statutorily recognized form of neglect for already overworked CPS caseworkers to investigate may seem unnecessary, expensive, counterproductive, and wasteful. But only about ten percent of divorcing couples are considered high conflict and intervention would only be mandatory after eighteen months of litigation.[152] A number of these cases may already be open with CPS as some high-conflict divorce cases are colored with domestic violence, substance abuse, and/or physical child abuse and neglect.[153] It is unfathomable to ignore the thousands of children who are currently disregarded by CPS simply because there is no substantiated claim of physical abuse or neglect. These children suffer through years of emotional neglect as their parents viciously fight to dissolve their marriage.[154]

It is estimated that a single divorce case costs the government $30,000.[155] The annual average cost of divorce for taxpayers is over $30 billion.[156] CPS involvement may entice parents to realize the detrimental effects of continued litigation and come to a resolution, saving not only the parties, but also the taxpayers and court system millions of dollars.[157] By addressing the emotional needs of the family, most importantly the children, CPS involvement may lessen the likelihood of juvenile

delinquency and societal issues faced by children of high-conflict divorce whose mental health needs are not adequately addressed.

VI. CONCLUSION

Sean and Michael were afforded the opportunity to have a caseworker provide services throughout their parents' divorce process.[158] It was clear that the brothers were emotionally neglected by their parents. Their parents had entirely lost their ability to recognize the harm their divorce was causing the children. If there had been a statutory protocol requiring CPS to investigate and intervene in cases involving the emotional neglect of children in high-conflict cases, these brothers would have been provided the appropriate services without exposure to baseless, shameful, and harmful allegations of sexual and physical abuse in addition to their parents' long, drawn-out, and contentious divorce. Mandating CPS involvement in high-conflict divorce cases can safeguard the emotional health of children and families while ensuring that the appropriate services are accessible.

NOTES

1. The New Jersey Division of Child Protection and Permanency is the Child Protective Services (CPS) unit of the New Jersey Department of Human Services.

2. A law guardian in New Jersey is appointed under N.J.S.A. 9:6-8.23 for any minor who is the subject of a child abuse or neglect proceeding. A law guardian is appointed to protect the minor's interests and help him express his wishes to the court. A law guardian is not a guardian ad litem. Law guardians are not intended to represent the best interests of the child. They are an attorney for the child, advocating for and expressing the child's desires to the court.

3. Michael is a fictional character created for the purposes of this Note. However, his story is based on similar cases and the general experiences of children victimized by parental high-conflict divorce.

4. Sean is a fictional character created for the purposes of this Note. However, his story is based on similar cases and the general experiences of children victimized by parental high-conflict divorce.

5. *See* L. v. G., 203 N.J. Super. 385 (1985). The court held that the relationship between siblings is an important and unique relationship. Children gain meaningful knowledge and experiences from fostering a relationship with their siblings. The court found the relationship between siblings to be irreplaceable. Furthermore, the court held that "siblings posses the natural, inherent and inalienable right to visit with each other," subject to the best interest of the children when they are not living with each other or placed in the same home.

6. *See* Linda D. Elrod, *Reforming the System to Protect Children in High Conflict Custody Cases*, 28 Wm. Mitchell L. Rev. 2 (2001).

7. *See* Janet R. Johnston, *Building Multidisciplinary Professional Partnerships with the Court on Behalf of High-Conflict Divorcing Families and Their Children: Who Needs What Kind of Help*, 22 Univ. Ark. Little Rock L. Rev. 453 (2000).

8. *Id*.

9. *Id*.

10. *Id*.

11. *Id*.

12. Solly Dreman, *The Influence of Divorce on Children*, 32 J. Divorce & Remarriage 41 (2000).

13. Janet R. Johnston, *High-Conflict Divorce*, 4 Child & Divorce 165 (1994).

14. *See* Morgan v. Getter, 441 S.W. 3d 94 (Ky. 2014) (The court held that "the duties of a guardian ad litem ('GAL') shall be to advocate for the child-client's best interest in the proceeding through which the GAL was appointed." The Family Court Rules of Procedure provide for the appointment of a GAL for the child in custody, shared parenting, visitation, and support proceedings. If the attorney's understanding of the child's best interests are in conflict with the child's wishes, the GAL shall inform the court of the conflict and indicate the child's wishes and reasoning. In the holding the court acknowledges the differences that exist across jurisdictions with regards to the appointment of a GAL or attorney for the child, and under which circumstances they are permitted.).

15. *See* Diane Somberg, *Defining the Role of Law Guardian in New York State by Statute, Standards and Case Law*, 19 Touro L. Rev. 530 (2014) ("In New York State, the Family Court Act ("FCA") states that minors involved in proceedings that originated in family court need to be represented by counsel." The article continues by listing the types of cases covered under the FCA including: child abuse or neglect cases, termination of parental rights applications, adoption applications, requests for an abortion where parents have not given consent to their pregnant daughter, civil commitment proceedings, child custody disputes, juvenile delinquency hearings, persons in needs of supervision (PINS) proceedings, and medical treatment issues. Accordingly, in New York a law guardian is an attorney for the child, which is different from a GAL. A law guardian in New

York State is an advocate as well as a GAL with a statutory mandate to represent the child's wishes and best interests. In New York a law guardian is required to be assigned for any case involving abuse and neglect, termination of parental rights, juvenile delinquency, and PINS cases.).

16. *See* ANN M. HARALAMBIE, THE CHILD'S ATTORNEY: A GUIDE TO REPRESENTING CHILDREN IN CUSTODY, ADOPTION, AND PROTECTION CASES (1993) (discussing the difference between the role of a GAL and an attorney for the child in the representation of children in parental conflict situations).

17. Jay Lebow & Kathleen Newcomb Rekart, *Integrative Family Therapy for High-Conflict Divorce with Disputes Over Child Custody and Visitation*, 46 FAM. PROCESS 79, 79–91(2006).

18. *See* Johnston, *supra* note 7.

19. *Id*.

20. *See* Elrod, *supra* note 6.

21. *See* Johnston, *supra* note 13. The nature of disputes and the personalities of parties may contribute to the likelihood of a divorce being high conflict.

22. *Id*. Feelings stemming from sadness, disappointment, and an inability to let go or acknowledge the end of the relationship may lead to repetitive litigation as one or both parties attempt to hold on to the imploding relationship. Several explanations exist for why certain couples are more prone to high-conflict dissolution. For example, the history of the marital relationship and the nature of the separation can cause couples to create "negative, polarized views of each other," which furthers the contentiousness of the divorce process. This article describes the nature of some prior relationships as creating extreme distrust between parties. Accordingly, this causes some parents to fight zealously to protect the children from what they perceive as the negative aspects of the other partner.

23. *See* Elrod, *supra* note 6, at 6–10.

24. *Id*. at 7.

25. *Id*.

26. *Id*.

27. *Id*.

28. *See* Johnston, *supra* note 13, at 171.

29. Lebow & Rekart, *supra* note 17.

30. *See* Johnston, *supra* note 13.

31. Michael E. Lamb et al., *The Effects of Divorce and Custody Arrangements on Children's Behavior, Development, and Adjustment*, 35 FAM. & CONCILIATION CTS. REV. 4 (1997). Parents are often unable to focus on the needs of the children because they are preoccupied by their own financial, emotional, and social stress.

32. Elizabeth S. Scott, *Divorce, Children's Welfare, and the Culture Wars,* 9 VA J. SOC. POL'Y & L. 95 (2001) The article discusses different views regarding how the emotional and physical welfare of a child is affected by high-conflict marriage and divorce. Within this article Scott references the longitudinal study of families by Paul Amato and Alan Booth. Although children are typically better off when their parents decide to end high-conflict marriages, the study suggests, "a surprisingly high percentage of marriages that end in divorce involve low or moderate levels of conflict." Accordingly, these marriages are "good enough" and have seriously negative impacts on the long-term well being of the children involved. A child is only better off when their parents divorce, if the marital relationship was marked by high-conflict.

33. *Id*. Children are generally better off when parents chose to end a high-conflict marriage.

34. Joan B. Kelly, *Children's Adjustment in Conflicted Marriage and Divorce: A Decade Review of Research*, 39 J. AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY 963 (2000).

35. Lebow & Rekart, *supra* note 17, at 79.

36. *See* Kelly, *supra* note 34, at 964.

37. *Id*. at 966. Girls and boys exhibit slight variations in the type and degree of problem behaviors. Boys are more likely to exhibit external behaviors such as "being suspended or expelled from school, getting in trouble with the police, or running away from home." *Id*.

38. *Id*.

39. *Id*. at 964. The article describes the different types of conflict and how it creates different emotional issues for children. For example, overt hostile conflict such as physical abuse or screaming causes externalizing behaviors in children. Covert conflict styles such as passive aggressive behaviors, unspoken tension, and resentment were linked to depression, anxiety, and other internalizing symptoms in children.

40. *Id*.

41. John H. Grych & Frank D. Fincham, *Marital Conflict and Children's Adjustment: A Cognitive-Contextual Framework*, 108 PSYCHOL. BULL. 267 (1990).

42. *Id*.

43. *Id*. at 275.

44. *See* Kelly, *supra* note 34, at 965.

45. *Id*.

46. *Id*. at 967.

47. *Id*. (stating substance use can be attributed to less effective coping skills, impaired parental monitoring and flawed parenting skills).

48. *Id*.

49. *Id*. at 965.

50. *Id*.

51. *Id*.

52. *See* Johnston, *supra* note 13, at 172.

53. *See* Kelly, *supra* note 34, at 967. The article reiterates the importance of the paternal role in parenting that is often jeopardized during divorce. Studies show when fathers remain involved in the child's academic life the child is more likely to perform better academically and avoid disciplinary issues at school.

54. *Id*. Lower academic achievement can be attributed to financial resources and parental monitoring being jeopardized during and after dissolution.

55. *See* Lamb et al., *supra* note 31, at 394.

56. *See* Grych & Fincham, *supra* note 41.

57. *See* Johnston, *supra* note 13; *see also* Kelly, *supra* note 34 (describing how adequate family functioning is often impaired when depression and/or anxiety color a parental mindset).

58. *See* Johnston, *supra* note 13. The article reiterates parental distress and continued conflict between parents often creates more strain for the parent-child relationship. Typically the relationship is already strained due to the inevitable shift in family dynamic during any family rearrangement. Not only does this stress make it more difficult for a child to adjust to the divorce, but it may also lead to more severe behavioral, developmental, and emotional complications for the child.

59. Kelly, *supra* note 34, at 967.

60. *See* Lamb et al., *supra* note 31, at 395.

61. *Id*.

62. *See* Kelly, *supra* note 34.

63. *Id*.

64. *Id*.

65. Sandra J. Kaplan et al., *Child and Adolescent Abuse and Neglect Research: A Review of the Past 10 Years. Part I: Physical and Emotional Abuse and Neglect*, 38 THE J. OF THE AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY 1214 (1999).

66. Jocelyn Brown et al., *Childhood Abuse and Neglect: Specificity of Effects on Adolescent and Young Adults*, 38 THE J. OF THE AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY 1490 (1999).

67. Joan McCord, *A Forty Year Perspective on Effects of Child Abuse and Neglect*, 7 CHILD ABUSE & NEGLECT 265 (1983). The article describes the outcomes of a study of abused and neglected boys. The study found abuse and neglect caused antisocial behaviors leading to increased rates of juvenile delinquency within this group. Additionally, paternal alcoholism, crime, and aggression facilitate a strong likelihood of continuing physical abuse and neglect.

68. *See* Brown et al., *supra* note 66. The authors reiterate disruptive family systems and inadequate parenting often contribute to maladjustment for children of abuse and neglect. Physically abused and neglected children often have delays in health, cognitive development, emotional adjustment, and socialization. Adverse family environments and specific characteristics of parent-child relationships often explain the link between childhood abuse and depression.

69. *Id*. Parents who are suffering with mental illness may be unable to control the abuse if it is being performed by their spouse or another caregiver. Additionally, parents may be blind to the abuse if they are preoccupied with their own issues, leaving the children without any protection within the home. Alternatively, parents may be performing the abuse due to their mental health issues.

70. *See* McCord, *supra* note 67, at 268; *see also* Brown et al., *supra* note 66 (The article indicates childhood abuse makes an individual three to four times more likely to be abused or suicidal in the future. Adults who were abused as children typically are at an increased risk for distress, mental health disorders, depression, and suicidal ideations).

71. KIERAN O'HAGAN, IDENTIFYING EMOTIONAL AND PSYCHOLOGICAL ABUSE: A GUIDE FOR CHILDCARE PROFESSIONALS (2006).

72. *Id*. at 25.

73. Danya Glaser, *Emotional Abuse and Neglect (Psychological Maltreatment): A Conceptual Framework*, 26 CHILD ABUSE & NEGLECT 697 (2002).

74. *Id*.

75. Judith C. Areen, *Intervention Between Parent and Child: A Reappraisal of the State's Role in Child Neglect and Abuse Cases*, 63 GEO. L.J. 887 (1975). The parens patriae power allows the state to protect children from abuse and neglect at the hands of their parents or caretakers.

76. Douglas J. Besharov, *"Doing Something" About Child Abuse: The Need to Narrow the Grounds for State Intervention*, 8 HARV. J.L. & PUB. POL'Y 539 (1985). The author discusses the history of CPS. The article states Vincent DeFrancis of the American Humane Association and Dr. Vincent J. Fontana of the New York Foundling Hospital were strong advocates for the creation of a centralized agency to receive and investigate reports of abuse and neglect). CPS is responsible for receiving and investigating allegations of child abuse and neglect.

77. *Id*. at 548. The Child Abuse Protection and Treatment Act was passed when national recognition and mass media coverage of child fatalities resulting from unreported and uninvestigated abuse became widespread. Additionally, the federal government encouraged the creation of CPS agencies by allocating grant money for the creation of these programs.

78. *See* Besharov, *supra* note 76, at 548; *see also id*. at 542 (discussing reporting laws requiring "certain" professionals to report instances of suspected child abuse; by 1967 all states had laws requiring physicians to report all physical injuries inflicted on children caused by nonaccidental means); How and When to Report Child Abuse/Neglect, N.J. Dep't Child &

Families, http://www.nj.gov/dcf/reporting/how/ (last visited Nov. 22, 2015) (describing the process for making reports of abuse and neglect to CPS). As indicated by Besharov, *supra* note 76, all states have anonymous hotlines for individuals to report child abuse and neglect. For example, in New Jersey the hotline is 1-877 NJ ABUSE. Any person that reasonably believes a child to be subject to abuse should call the hotline.

79. *See* Besharov, *supra* note 76, at 545.

80. *How and When to Report Child Abuse/Neglect*, *supra* note 78.

81. *Id*.

82. *See* Besharov, *supra* note 76, at 549.

83. *Id*.

84. *Id*. CPS generally helps a family obtain services including financial assistance, therapy, or parenting classes.

85. *See id*. The author discusses the possibility that parents or caregivers may not be compliant or cooperative with services. In such cases, court intervention is necessary to implement care plans/services. According to this article only about fifteen percent of substantiated cases result in civil court actions to enforce services. Similarly, less than five percent of cases result in criminal prosecution.

86. Andrea J. Sedlak et al., *Child Protection and Justice Systems Processing of Serious Child Abuse and Neglect Cases*, 30 CHILD ABUSE & NEGLECT 657 (2006). This article discusses the different roles of CPS and law enforcement in dealing with allegations of abuse and neglect. This article indicates it is up to the prosecutor to determine whether or not to prosecute a case for child abuse. Typically court involvement is limited to civil or family court intervention to require participation in the therapeutic interventions recommended by CPS. These interventions include recommendations to family or individual therapy.

87. *Id. at* 660. CPS will petition the court for the power to provide care and supervision of the child if they remain in the home in order to ensure compliance with therapeutic interventions and continual safety plans.

88. *Id*. at 660.

89. *See* Areen, *supra* note 75, at 927. Mental health and social science experts are well aware of the effects of emotional neglect on children.

90. *See* Glaser, *supra* note 73, at 697.

91. *Id*. at 699.

92. *Id*. at 698.

93. Kaplan et al., *supra* note 65.

94. *See* Glaser, *supra* note 73.

95. *Id*. at 705.

96. *Id*.

97. Patrick T. Davies & E. Mark Cummings, *Marital Conflict and Child Adjustment: An Emotional Security Hypothesis*, 116 PSYCHOL. BULL. 387 (1994).

98. *See* Areen, *supra* note 75. When parents are unable to provide adequate emotional support due to personal preoccupation, they continuously place their children in stressful situations.

99. *See* Lamb et al., *supra* note 31.

100. *Id*.

101. *See* Kelly, *supra* note 34, at 964 (describing the emotional effects of high conflict divorce on children); *see also* Kaplan et al., *supra* note 65 (discussing the lasting social, emotional, and educational effects of physical abuse and neglect on children).

102. Kelly, *supra* note 34, at 964. Children of divorce are also generally more at risk for depression as young adults similar to children who are physically abused and neglected; *see also* Brown et al., *supra* note 66 (describing the lasting effects of physical abuse and neglect on children); *see also* Kelly, *supra* note 34, at 964 (describing the effects of high conflict divorce on children).

103. *See* O'HAGAN, *supra* note 71, at 17. The author describes a case where a caseworker attempted to bring a case against a parent for emotional neglect. Supervisors at CPS requested the caseworker indicate what physical injuries the child sustained. The caseworker observed emotional neglect that was substantiated by the observations of other professionals, however, in order for a case to be opened a bruise on the child's body had to be used as evidence of physical abuse. This section of the chapter indicates caseworkers are enticed to only pursue physical abuse and neglect. The point of this story is to show CPS is unlikely to open a case for emotional neglect, because it is hard to prove, define, and identify. Therefore, emotional neglect often is unreported and unsubstantiated.

104. *See generally* Areen, *supra* note 75, at 927. In fact, some courts have specifically indicated emotional danger has no place in neglect proceedings.

105. *Id.; see also* Johnston, *supra* note 13, at 168 (stating although allegations of neglect or abuse are often made during high-conflict dissolution, they are often dismissed by CPS workers because they feel they are only "indicators of inter-parental spite, impossible to prove, or insufficiently serious to require state intervention").

106. *Id*. at 903.

107. *Id*. at 912.

108. *Id*. at 927–28.

109. *Id*. at 928.

110. *See* Glaser, *supra* note 73.

111. *Id*. at 698. The state must exercise its parens patriae power to intervene on behalf of the children in these cases.

112. *Id*. at 705. CPS must be responsible because courts, lawyers, and laypersons are often unable to identify emotional neglect.

113. *Id*.

114. Christine A. Coates et al., *Parenting Coordination for High-Conflict Families*, 41 FAM. CT. REV. 1 (2003). The number of high-conflict divorce cases is relatively low. The number of cases, which will be statutorily required to be referred for CPS investigation after eighteen months of litigation, will be an even smaller percentage. Coincidentally, the number of cases requiring further court intervention and the appointment of an attorney for the child will be even smaller. Therefore, it is argued the burden of protecting the children will not have grave repercussions on the functioning of the court or CPS.

115. *Id*. Additionally, parents continue to emphasize their destructive opinions of each other, which inflicts further emotional harm on the children.

116. *See* Areen, *supra* note 75.

117. *Id*. at 903; *see also* Kristen Shook Slack et al., *Understanding the Risks of Child Neglect: An Exploration of Poverty and Parenting Characteristics*, 9 CHILD MALTREATMENT 395 (2004).

118. *Id*.

119. *See* Glaser, *supra* note 73.

120. *See* Areen, *supra* note 75.

121. *See* Glaser, *supra* note 73; *see also* Lamb et al., *supra* note 31.

122. *See* Areen, *supra* note 75, at 933. This article discusses the importance of specifically defining emotional health in a model statute. This article proposes intervention be supported by evidence the child is suffering from a specific list of mental health disorders including anxiety, depression, withdrawal, aggression, or hostility. Additionally, the article argues for an exhaustive list of signs and symptoms to support a finding of emotional neglect.

123. *See* Johnston, *supra* note 13, at 171 (describing high-conflict divorce as marked by repetitive litigation perpetuated based on extreme levels of mistrust, anger, aggression, and hatred between parties); *see also* Areen, *supra* note 75. The emotional effects on children may not be recognizable to lawyers, judges, or parents.

124. *See generally* Areen, *supra* note 75.

125. *See How and When to Report Abuse/Neglect, supra* note 78.

126. Glaser, *supra* note 73, at 705. When family dynamic is a cause for concern, for example, in high-conflict martial relationships, there is a need for investigation to determine whether there is emotional neglect.

127. *See* Lamb et al., *supra* note 31. This article discusses the nature of divorce in general and arguing parents become less likely to gainfully or productively contribute to the emotional needs of their children based on their own inability to appropriately deal with the traumatic divorce experience. Additionally, these stressors are extenuated and more harmful to the children in high-conflict cases.

128. *See* Kelly, *supra* note 34, at 964 (describing the presence of the listed factors as more likely to be exhibited by children involved in high-conflict marriages and divorces as opposed to children from low-conflict marriages, and subsequent divorces).

129. *Id*. When intense parental conflict is centered around issues such as child care, support, parenting time, or the children's activities, generally, children are more likely to feel shameful, to blame, or fearful of the outcome of the conflict.

130. *Id*. at 967.

131. *See* N.J. DEP'T CHILD. & FAMILIES, *supra* note 80.

132. *See* Besharov, *supra* note 76; *see also* Sedlak et al., *supra* note 86. The role of CPS with regards to emotional neglect cases will be no different than a traditional physical abuse or neglect case. CPS will use therapeutic interventions and operate from a social work perspective.

133. *Id*.

134. *See* Glaser, *supra* note 73. Parents may not be aware because they are preoccupied with the divorce process.

135. Sedlak et al., *supra* note 86, at 660.

136. *See* Somberg, *supra* note 15, at 533 (explaining the right to counsel was extended to children with the passing of CAPTA; CPS agencies were only entitled to federal aid if state legislatures enacted laws ensuring a child involved with CPS proceedings would be granted a GAL).

137. Some states have already started implementing similar programs. However, this Note advocates for nationwide protection for children in high-conflict dissolution proceedings.

138. *See* O'HAGAN, *supra* note 71, at 25. The author discusses the failure of child welfare systems to address emotional neglect unless it is attached to physical abuse or neglect. Further arguing most supervisors in child welfare organizations require a finding of physical abuse or neglect to open cases and provide services to families.

139. *See* Johnston, *supra* note 13.

140. Areen, *supra* note 75, at 927.

141. Wilma J. Henry et al., *Parenting Coordination and Court Relitigation: A Case Study*, 47 FAM. CT. REV. 682 (2009).

142. Coates et al., *supra* note 114.

143. *See* Henry et al., *supra* note 142 (This article discusses the relationship between long, drawn out, court involvement and the serious emotional and behavioral effects it has on children and their relationship with "one or both of their parents." Reiterating the point that high-conflict divorce often poses "substantial emotional risk and psychological harm to the children who are victims of the resulting parental discord.").

144. *Id.; see also* Glaser, *supra* note 73. As parents become more entrenched in the emotional, financial, and social stress of high-conflict divorce, especially when conflict continues for extended periods of time, they become less likely to sustain strong emotional or even physical ties to the children. Parents become less likely to acknowledge the toll the high-conflict divorce is taking on a child's emotional well-being.

145. Areen, *supra* note 75.

146. Glaser, *supra* note 73.

147. *Id*.

148. *Id*. at 699; *see also* Lebow & Rekart, *supra* note 17. Although the number of high-conflict divorces as compared to the total number of divorces in the United States is relatively low, almost two million children in the past two decades have been victimized by high-conflict parental dissolution.

149. *See* O'Hagan, *supra* note 71, at 25.

150. *See* Areen, *supra* note 75. Trained caseworkers with a social work background can conduct an investigation to determine the possibility and/or existence of emotional neglect.

151. *See* Haralambie, *supra* note 16. Appointment of an attorney for the child (AFC) is commonplace in physical abuse and neglect cases.

152. Henry et al., *supra* note 142; *see also* Johnston, *supra* note 7. Although proportionality small in number, these cases are not only detrimental to the emotional health of the entire family unit, but also consume a "disproportionate amount of the court's time and resources."

153. *See* Elrod, *supra* note 6.

154. *See* O'Hagan, *supra* note 71; *see also* Glaser, *supra* note 76; *see also* Johnston, *supra* note 7.

155. *Id*. at 683. This amount takes into consideration the costs associated with acts of juvenile delinquency performed by children of divorce.

156. *Id.; see also* Johnston, *supra* note 7. The author discusses how this small group of divorcing couples uses a disproportionate amount of the court system's resources with grim legal outcomes. The longer a case is open, the more money the court system and taxpayers are forced to pay.

157. *Id*.

158. Sean and Michael are two fictional characters created for the purpose of this Note. Their story is based on similar cases observed in family court proceedings where there was high conflict and emotional neglect.

Alexa would like to thank her family, friends, and employers for their continued support, patience, and inspiration.

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SPECIAL ISSUE ARTICLE

Parent-child contact problems: Family violence and parental alienating behaviors either/or, neither/nor, both/and, one in the same?

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Abstract

This article argues that in order to intervene effectively and ethically with children who are manifesting Parent–child contact problems (PCCPs) after parental separation, we begin by being mindful of what is normal about divorce transitions and use developmentally appropriate and culturally sensitive analysis to rule out children's common transitory reactions. It is then important to concurrently assess for both family violence (FV) and severe parental alienating behavior (PAB) on the part of both parents, which can co-occur in some cases. The article asserts that it is also important to consider common problematic parenting responses that may potentiate the PCCP but not necessarily rise to the level of abuse. FV is defined as a child's direct experience of physical, sexual, or psychological maltreatment and indirect exposure to sibling abuse and/or to intimate partner violence (IPV). PAB is defined as an ongoing pattern of unwarranted negative messages on the part of one parent that conveys that the child's other parent is disinterested, irrelevant, dangerous, and not to be trusted. Any one or all of these factors may contribute to a child's strident negativity and sustained rejection of one parent, these being defining features of a PCCP. This article proposes ethical principles and priorities for decision-making in these cases, considering the growing social science controversy about assessment and intervention for PCCPs. It concludes with

an analysis of recent, contrasting policy approaches to PCCPs (e.g., Kayden's Law and the Joint Statement of the AFCC and NCJFCJ) and their potential impact on family justice system professionals and the families they serve.

KEYWORDS
domestic violence, intimate partner violence, Kayden's law, parental alienating behaviors, parental alienation, parent–child contact problems

Key points for the family court community

- This article provides more precision in defining Parent–child contact problems, Family Violence, Parental Alienation, and Parental alienating behaviors.
- This article asserts that in addition to forms of violence in families such as sexual and physical abuse and IPV, severe PABs represent a form of FV akin to psychological maltreatment.
- We offer a framework that prioritizes the safety of child and victim parents, with a focus on safety in the face of parental conduct that is damaging, possibly abusive, not protective.
- Two recent public policy approaches to addressing Parent–child contact problems, Kayden's Law and the NCJFCJ/AFCC's joint statement are discussed.

Parent–child contact problems (PCCPs) refer to a spectrum of family dynamics that result in a child developing resistance and sometimes refusal to have contact with one of their parents. PCCPs occur on a continuum of severity, legal and psychological interventions have been developed to attempt to fit the nature and severity of the particular case (Fidler & Bala, 2020, Judge & Deutsch, 2016). Some common reasons for PCCPs developing can include historically limited marginal parental involvement in the child's life, poor parental attunement to the child's needs, and the poor handling of children's normal developmental adjustment to shared parenting arrangements (developmental and attachment issues, dissatisfaction with current parenting arrangements, etc.). Other common reasons include children's response to interparental conflict (aligning with a parent to cope with being caught in the middle of parental conflict), and children's response to severe problems in parenting and coparenting.

PCCPs can be a response to family violence (FV), which is an umbrella term for various kinds of violence that include child abuse, neglect, and intimate partner violence (IPV). Parental alienation (PA) is a type of PCCP where a child, for no adequate or justifiable reason, expresses negative attitudes, beliefs, and behavior toward one of his/her parents primarily due to the preferred parent's denigrating attitudes, beliefs and sabotaging behaviors. A finding of PA should only occur when the dominant single factor contributing to the child's resistance and refusal is a pattern of PABs by the preferred parent.

Multi-factor models of PCCPs assert that, although one factor may dominate its contribution to the PCCP, more typically, PCCPs stem from many, interacting factors that have contributed to the current situation (Drozd & Olesen 2004; Fidler & Bala, 2010; Johnston & Sullivan, 2020; Kelly & Johnston, 2001; Olesen, 2021). Therefore, effective assessment and intervention requires a multi-pronged understanding and approach to the problem that incorporates the entire family system.

PCCPs are increasing in prevalence in the family justice system, particularly in more adversarial processes such as parenting plan evaluations and litigation (Bala et al., 2010; Harman et al., 2022; Lorandos, 2020; Marques et al., 2020). This increasing prevalence is likely the result of several social/cultural and legal movements in the last half century, including advocacy movements to advance awareness and interventions to protect family members impacted by IPV, the father's rights movement and their efforts to advocate for more equal paternal involvement and shared parenting time, and the recognition that children's voices must be meaningfully considered in legal proceedings that impact them (Johnston & Sullivan, 2020). These advocacy movements, each one laudable in their primary intent, have collided in ways that create conflicts between groups. The conflicts have trickled down to social science researchers and practitioners in the family justice system who, in their efforts to understand the issues and support children and families in practice, have unwittingly, replicated conflicting advocacy stances. The tensions and conflict that begin by earnest attempts to redress inequities in the court system get further exacerbated by adversarial court processes, contributing to further polarization as well as actual and/or perceived victimization on all sides. The internet has widened the scope of the problem by way of unvetted sources of information, such as blog sites, personal narratives in the public domain through books, magazines, and social media. Parents have easy access to "unvetted information from unknown, often biased and irresponsible sources" (Johnston & Sullivan, 2020, p. 277). Further, search algorithms operate in ways that give priority to selective information based on the individual user's previous search history. Thus, individuals obtain information from sources that, without their awareness, reinforce their view in a feedback loop, contributing to the polarization evident in the professional context of high conflict parenting disputes. Inflamed by biased perspectives and misinformation, conflicts between parents get supported and heightened, leading to disputes that swirl around the children, increasing the risks of long-term negative sequelae for all family members.

MANY TYPES OF PCCPs

Despite the rapidly expanding research and clinical attention given to one subtype of PCCP, parental alienation (PA) (Lorandos, 2020; Sheehy & Lapierre, 2020), understanding how to differentiate dynamics occurring across the spectrum of distinct but interrelated PCCPs in vulnerable separating families and intervene accordingly is still an elusive enterprise in family law.

In the process of polarization, FV concepts are often pitted against those of PA, vying for endorsement as legitimate social problems. There is a strong social science base regarding the negative, often traumatic, impact of IPV and child maltreatment on children and parents who have experienced these types of Family Violence. The literature on PA phenomena is less robust but developing quickly. For example, Harman et al., 2022 reports a 40% increase in parental alienation research, defined broadly, since 2016. Similar trends have been reported by others (Lorandos, 2020; Marques et al., 2020; Templer et al., 2016). It is well accepted that strategic deployment of PABs manifest as extensions of male-controlling battering in domestic abuse situations with some frequency. Some authors hold that parental denigration of the other parent can be another form of FV, perpetuating ongoing coercive control in the coparental relationship through the children (Harman et al., 2021; Warshak, 2015). Others argue that PA, a specific form of PCCP where one parent consistently and emphatically undermines the child's relationship with the other parent, can be falsely alleged in court proceedings as a counterattack to allegations of Family Violence (Meier et al., 2019; Milchman, 2019). These polarizations mirror the myth that a child who resists or refuses contact with a target parent is either a victim of abuse by that parent or a victim of PABs by the preferred parent, but not

both (Johnston & Sullivan, 2020). Cases are frequently presented in court as false dichotomies in which the child's preferred parent is the alienator or PA perpetrator and the rejected parent is the innocent victim, or the child is resisting or refusing access to a parent because they have been a victim of maltreatment. In fact, the PCCP may derive from a complex interplay of multiple dynamics occurring within the family over time.

The confiscation inherent in definitions of PA juxtaposed against IPV is augmented by the fact that "concept creep"[1] has led to an ever-expanding list of behaviors and attitudes that are included in the definition of PA. As Harman et al. (2022) note, the research literature on PA appears to be less substantial than the volumes of related studies that capture the same phenomena using different terminologies (p. 1890). Allegations of PA are now used to explain false allegations of child abuse or neglect against a rejected parent; to counter evidence of IPV and/or child maltreatment; to label efforts by an abusive ex-partner; to maintain coercive control. It also responds to relocation petitions, parental abduction situations, and over-restrictive gatekeeping of an unfriendly, unsupportive, non-cooperative ex-partner. The lack of clarity is further confounded by the problem that no bright line exists addressing adverse parenting practices between abuse and non-abuse in parenting plan dispute cases in family courts. Despite agreement that a finding of IPV and/or child maltreatment precludes a finding of PA (Fidler et al., 2013), there are no universal criteria to define these distinctions. PA itself is an ambiguous term (Pruett et al., 2023), despite assertions otherwise by PA advocates (Bernet et al., 2010; Harman et al., 2022). Does it mean the parent is the alienator or the child is alienated, either or both? What is the relationship between PABs and PA? Imprecise language in the definition is problematic because it sets up tautologies (the name describes the outcome it is supposed to measure), and the lack of consensus in the field (Pruett et al., 2023) does not allow for the nuanced distinctions that would resolve the problems of ambiguous concept names created.

This article begins with the premise that PA/PABs and Family Violence are real phenomena—and that the scope, prevalence and developmental implications of these phenomena necessitate urgent empirical, clinical and public policy responses. For that to happen productively, the field must come together not in its beliefs, but in its definitions, understanding the relevance of science and differentiation of how these dynamics (individually and in combination) are imperative to assessment and subsequent delineation of appropriate interventions. Implications for assessment, intervention, and public policy will be discussed.

TOWARD A CALCULUS OF ETHICAL PRINCIPLES FOR INTERVENTION IN PCCP CASES

Mounting evidence exposes the developmental risks children face when one parent "shuts down" their relationship with another parent who has not been violent (Harman et al., 2018; Von Boch-Galhau, 2018). Moreover, children (especially very young children) benefit from having relationships with two or more good enough caregivers (Ryan et al., 2019). Apart from the risks to child well-being, the problem of PCCPs raises a myriad of human (civil) rights and ethical issues. The family courts have been accused of institutional gender bias and justice system practitioners of procedural injustice in their attempts to balance the needs, claims, and rights of disputing family members who are also victims of IPV (Meier, 2020). In these matters, accountability and transparency for case disposition follows where a consistent set of ethical principles that guide decision-making can be articulated, especially where relevant facts are ambiguous and social science evidence on the Best Interests of the Child (BIOC) is thin.

Family courts and dependency (juvenile) courts share several priorities in addressing IPV, child maltreatment, and PA cases pertaining to children (Johnston, 2016). First and foremost is to protect the child from abuse and violence. Second is to secure the child's relationship with at least one parent who offers emotional security and physical protection. This is enabled by protecting the denigrated parent's or victim's parent's security and autonomy to care

[1]First described by Haslam (2016), concept creep refers to the expansion of a set of harm-related concepts over time. Semantic inflation results in the inclusion of an increasingly wide range of phenomena referring to one concept (also see Haslam et al., 2021). The "creep" often is motivated by political actors (Sunstein, 2018) wanting to strengthen their advocacy position by broadening the sense of its breadth and influence.

for the child. The third priority is to promote and protect the child's involvement with and access to both parents, assuming safety and security are in place (Johnston, 2016). Moreover, the courts in democratic societies must proceed to maintain the freedom and civil rights of all individuals, including children, from undue, unwarranted, or disproportionate state interference. A child-centered approach (BIOC) involves never relinquishing the first and primary priority. The second and third priorities are revisited when safety is achieved, with the goal of achieving parental inclusivity once safety and security are established or court orders and/or interventions are in place to support and monitor progress toward rehabilitation and repair. This hierarchy of child protection is impossible to achieve if practitioners and professionals are confused about the definitions and meanings of the terms and dynamics under consideration: yet recent research suggests that this is precisely the situation.

In a large study of family court professionals, the current authors found that among 1049 experienced family law professionals, respondents were evenly split in their belief that they understand the difference between PA-related terms (Pruett et al., 2023). Their consensus was that PA is a valid phenomenon with PABs a common occurrence. Demonstrating the endorsement of conflicting beliefs, PA was understood to co-occur with other types of Family Violence yet there was no consensus, and over half of respondents were undeclared about whether PA more often co-occurs in parenting plan dispute cases alleging IPV. In all, a third of respondents believe that PA is a flawed concept, and as an example of the confusion in the field, nearly half endorsed that PA can occur without the central defining feature of the concept (i.e., a parent who intentionally alienates a child from the other parent). The data indicated confusion about the role of this single dominant construct. Even with the current amount of writing and research about PA concepts, unfortunately there no prevalence data on what is a common PCCP case where a dominant single factor of IPV, child maltreatment, or PA is alleged and not found, so that ultimately other factors are contributing to the PCCP.

THE SINGLE-FACTOR PA THEORY

The dominant or single-factor version of PA arguments (Johnston & Sullivan, 2020; Joyce, 2019) offer a deceptively simple explanation and legal remedy: a child's unwarranted negative attitudes and behavior toward a target parent, with whom they had a previously good relationship, are primarily due to the PABs of the preferred parent. The *cause* (A) is systematic programming by a favored parent; the *effect* (B) is manifestations of programming in the child, and the *remedy* (C) in severe situations is change of parenting time to the target parent and isolating the child from the preferred parent. This transfer was reported as being "very effective" in "severe" cases of PA (Harman et al., 2022, Warshak, 2010), as were orders for the child to spend more time with the rejected parent (Warshak, 2019). However, the single-factor theory assumes that child abuse and IPV have been ruled out, as have alternative explanations for PCCPs. Yet clinical experiences reveal that PA and FV dynamics often exist in tandem, and court evaluations are rife with clinicians trying to separate the contributing factors to recommend interventions. In addition, many PCCP cases have no evidence of either FV or PA/PABs (even though one or both may be alleged). Clearly, the A-B-C theory does not adequately account for context, as does the multi-systemic theory below. Moreover, research is lacking that contains clear definitions of PA/PABs, showing there are not clear distinctions between the concepts and their concomitant behaviors and outcomes.

Problems arise when practitioners and legal professionals overstate the social science evidence under pressure of scholar advocacy for decisions, assume a deterministic rather than a probabilistic relationship among the variables contributing to A and B above, confuse association with causation, and confuse ideology with scientifically derived evidence. If this confusion is influencing the field, then we cannot expect better outcomes for the children and families with whom we are working clinically or legally.

THE MULTIPLE-FACTOR PCCP THEORY

The literature on PCCPs provide several multi-factor, system-based models that identify the complex interplay of many factors within individual family members (personality vulnerability in parents, child temperament, age),

between family members (interparental conflict, pathological parent–child attachment), extended family influences (grandparents, new relationships), and factors external to the family (involvement by mental health professionals, court, or social service agencies) that can contribute to PCCPs (Kelly & Johnston, 2001; Johnston & Sullivan, 2020). These models caution family justice professionals against making prior assumptions about any singular or dominant "cause" of a child's rejection of a parent in any case. This is particularly when other specified factors are present and rather encourage an approach to these cases that systematically assesses all factors that contributed to the current family dynamics to effectively intervene in any particular case. Drozd et al. (2020), for instance, suggest a decision tree that includes consideration of normal developmental affinities for one parent over another at various ages and stages, responses to abuse (child, IPV, parent substance abuse), child vulnerabilities stemming from childhood experiences or problems, and parenting difficulties such as behaviors toward the child that are too rigid or lax, overinvolved and intrusive, mis-attuned, or denigrating of the other parent. Fidler & Ward (2016) describes factors that differentiate characteristics and severity of the PCCPs, and models for gathering and analyzing information garnered about a particular family in a structured and consistent manner. Another approach posits four primary factors that predict outcomes in treatment (Johnston & Sullivan, 2020).

According to this multi-factor theory, an array of developmental and problematic factors can combine to create an alliance with one parent against the other. PABs by the preferred parent is an important but not necessarily the dominant factor accounting for PCCPs characterized by children's resistance or refusal of contact with a parent following parental separation. The context of behaviors and emotions of all family members include influences on children's negative stance toward one parent deriving from child, parent, coparent, parent–child, sibling, and multigeneration (e.g., grandparent) characteristics.

Even in the more prevalent types of PCCP situations, for example where a child's response to IPV or parenting problems, including maltreatment, is the dominant factor in a child's resistance to contact with a parent compared to the less prevalent situation where the PABs by the favored parent is the dominant single factor in a child's resistance to a parent, approaching cases with an "anchoring bias" is likely to lead to errors in accurately identifying critical case dynamics. An anchoring bias is an assumption or bias that we generate as our first impression of a case. It's our initial "take" and sets up the likelihood of another common cognitive bias, confirmatory bias, where we selectively collect and evaluate information to confirm the initial bias (Simon & Stahl, 2014). Anchoring biases may dominate for a variety of reasons, including but not limited to insufficient professional training in assessment of all topics related to PCCP cases, professional practices that have a specific emphasis (particularly IPV and PA), personal experiences that impact views, media information sources that are biased, and an ongoing predominant association with advocacy positions or groups. This latter example is known as the "echo-chamber phenomenon".[2] By participating in an echo chamber, people are exposed solely to information that reinforces their existing views without encountering opposing views, potentially resulting in an unintended exercise in confirmation bias. Echo chambers may entrench social advocacy positions and extremism, which trickle down to all of our social institutions, including the family justice system.

Preventing these source biases can be helped by assuming a multifactor approach to data collection and analysis with four recommendations: (a) approaching each case individually and testing multiple hypotheses while collecting information and considering both confirming and disconfirming data; (b) using structured protocols and checklists for screening and assessment (e.g., B-SAFER for IPV – Storey et al., 2014; Kebbell, 2019; Decision Making Trees for Parenting Plans and Custody Evaluations—Drozd et al., 2013; structured data collection for PCCPs—Fidler & Ward, 2016); (c) training in all areas of study relevant to PCCPs, especially those areas of subspecialty with which the professional is less familiar; and (d) engaging with professionals from other specialties that emphasize or advocate positions in the field.

[2]"… an echo chamber refers to situations in which beliefs are amplified or reinforced by communication and repetition inside a closed system and insulated from rebuttal". Echo chambers limit exposure to diverse perspectives, and reinforce presupposed narratives and ideologies. https://en.wikipedia.org/wiki/Echo_chamber_(media)#:~:text=In%20news%20media%20and%20social,system%20and%20insulated%20from%20rebuttal.

In clinical roles, professional guidelines offer considerations for best practices, such as the Guidelines for Court Involved Therapy created by a Task Force of the Association of Family and Conciliation Courts (AFCC, 2009) and (also see the white paper article regarding the Guidelines by Fidnick et al., 2011). The Guidelines enumerate best practices that include assessing levels of court involvement, identifying professional responsibilities, maintaining advanced training and competency levels, avoiding multiple relationships that could represent a conflict of interest, making clear fee arrangements, obtaining informed consent, maintaining privacy, confidentiality and privilege, following recommended procedures and methods, keeping appropriate documentation, and paying attention to what is communicated to whom in a case. These guidelines attempt to support professionals acting in a child's best interests at the highest level of professional responsibility, that focuses on holding multiple hypotheses and engaging in procedures that are comprehensive, balanced, fair, and sensitive to ethical dilemmas rife in psycho-legal work.

CONCEPTUAL DISTINCTIONS BETWEEN PCCPS, PA, IPV AND CHILD MALTREATMENT

We have argued that PCCPs include a complex spectrum of issues that can result in a child developing resistance and refusal to have contact with a parent. PCCPs are not equivalent to PA, IPV, or child maltreatment. In fact, from our clinical experience, cases where a dominant single factor drives a PCCP, such as FV or PA, are not as prevalent nor as challenging to address as are cases where multiple factors contribute to the problem. Even more challenging and quite common are the PCCP cases where neither FV nor PA are "found," and there is a mandate (by agreement of the parents or the court) to address the PCCP by working to reconnect the rejected parent and child. In these cases, children resist and refuse contact with a parent without an abuse-related reason, yet behave and express negative opinions adamantly and often vehemently. Whereas both parents can be assessed to support the child's relationship with the rejected parent, the child's well-being is pitted against the rejected parent's desire for a relationship, eliciting angst among all members of the family triad and professionals involved.

WHY THESE DISTINCTIONS MATTER

While debates about definitions and appropriate interventions swirl within scholarly circles, (Bernet et al., 2010; Meier et al., 2019; Milchman et al., 2020; Nielsen, 2018; Warshak, 2020; Harman et al., 2022, Fidler & Bala, 2020, Hardesty and Ogolsky, 2020) in the trenches of the family courts and with professionals who work in these complex, real-world cases, the impact of poorly managed increasingly intractable PCCPs on children are experienced in our daily work. Cases presenting with child maltreatment, intimate partner violence and parental alienation all create challenges, risk, and complexity to understanding and intervening in the case. Lost in these debates is that many types of PCCPs can contribute to extremely adverse child developmental impacts. A wrong decision can result in a child's loss of bonds to one or both parents (Warshak, 2019). Waiting too long to figure out what is happening in the family can lead to entrenchment of the child's avoidance of the rejected parent. Multi-generational consequences may include loss of extended kin relationships. At the severe end of the risk continuum, safety risks such as a child living in the exclusive care of a disturbed or abusive parent or death, highlight the ultimate potential risk to children in these cases (Meier et al., 2019). Also tragic are "parentectomy" outcomes where a parent and their side of the family are expunged from a child's life by the ongoing campaign of PABs perpetrated by another parent (Baker, 2005).

With so much at stake, it is imperative to maximize concept precision, accurate assessment, and treatment planning as early in the identification of PCCPs as possible. The likelihood of these pernicious outcomes is minimized when professionals correctly understand and assess the problem while recommending appropriate treatments. With overlapping characteristics in subtypes of PCCPs, the risk of assessment errors are high when referring a family for

PA intervention without recognizing that restrictive gatekeeping behaviors (Austin et al., 2013) can serve as the protective basis for one parent cutting off another from a child, and can risk doing further damage to the family. Similarly, in some cases, missing one parent's controlling and coercive behaviors that damage or severe a child's relationship with an adequate parent has damaging consequences that are very difficult to mend.

PARENTAL ALIENATION

We have asserted above that the definition of PA is often missing the context central to the concept. PA is used to refer to the alienating behavior of the parent, the characteristics of an alienated child, and a theory of how alienation occurs. PA refers to family situations where a child, for no adequate or justifiable reason, expresses negative attitudes, beliefs, and behavior toward one of his/her parents primarily due to the preferred parent's denigrating attitudes, beliefs and sabotaging behaviors (Baker, 2005; Bernet et al., 2010; Gardner, 2002). We argue that PA is a type of PCCP where the dominant single factor contributing to the child's resistance and refusal is a pattern of PABs by the preferred parent. When the PCCP has multiple contributions, these cases are not PA cases; they are another type of PCCP case. Similarly, child estrangement is a type of PCCP, where the dominant single factor contributing to the child's resistance and refusal to have contact with a parent is a response to the rejected parent's behaviors (past or current). These can be child maltreatment, intimate partner violence, or deficient parenting practices, including PABs by the rejected parent.

What are parental alienating behaviors (PABs)?

PABs are defined as "an ongoing pattern of observable negative attitudes, beliefs and behaviors of one parent (or agent) that denigrate, demean, vilify, malign, ridicule, or dismiss the child's other parent … together with the relative absence of observable positive attitudes and behaviors, (affirming the other parent's love/concern for the child, and the potential to develop and maintain the child's safe, supportive and affectionate relationship with the other parent)" (Johnston & Sullivan, 2020, p. 283). Harman et al. (2018) further state that PABs are not discrete events, they are enacted over time and alongside other behaviors with the intent of hurting, damaging or destroying the child's relationship with that parental figure and/or that parental figure themselves.

PABs are observable behaviors by parents that can contribute to a child's emotional distancing or rejection of one or both parents. For example, in some cases, PABs have a damaging impact on the child's relationship with both parents (Rowen & Emery, 2019). In higher conflict shared parenting arrangements or in cases where the child has more of an alliance with one parent (stronger attachment, more dependency, more parenting time, etc.), the impact of parents who engage in PABs typically have a differential effect on the other parent–child relationship, creating an "unholy alliance" (Johnston et al., 2009). This further reinforces the child's negative view and rejection of the parent with whom the child is not aligned. Professionals in family law consider PABs to be emotionally damaging to a child (Pruett et al., 2023), which when severe, are a form of child maltreatment and FV characterized by coercive control (Von Boch Galhau, 2018; Harman, et.al., 2018; Harman, et al. 2020; Milchman et al., 2020).

WHAT IS FAMILY VIOLENCE (FV)?

In this article, we define Family Violence as child maltreatment (physical, sexual, emotional) and intimate partner violence (IPV) which has traumatic impact on the domestic partner and on the child both through direct and indirect exposure (AFCC Guidelines for Examining IPV, 2016; also see the Battered Women's Justice Project, https://bwjp.org). We further assert that in addition to these forms of violence, severe PABs occurring in parenting plan dispute

cases, is a form of FV akin to psychological maltreatment. The American Professional Society on the Abuse of Children (APSAC) defines psychological maltreatment as "a repeated pattern or extreme incident(s) of caretaker behavior that thwart the child's basic psychological needs (e.g., safety, socialization, emotional and social support, cognitive stimulation, and respect) and convey a child is worthless, defective, damaged goods, unloved, unwanted, endangered, primarily useful in meeting another's needs, and/or expendable" (APSAC, 2019). Legal definitions vary across states and may include both indicators of the perpetrator's behavior and the effects on the child, more often focusing on the child's outcomes.

Six subtypes of psychological maltreatment are identified, with the one most relevant to the present paper being *Exploiting/Corrupting*. This describes caregiver acts that encourage the child to develop inappropriate behaviors and attitudes (i.e., self-destructive, antisocial, criminal, deviant, or other maladaptive behaviors). Among others, these acts are characterized as modeling, permitting, or encouraging betrayal or being cruel to another person. These acts also subject the child to belittling, degrading, and rejecting treatment of parents, siblings, and extended kin, coercing the child's submission through extreme over-involvement, intrusiveness, or dominance, and manipulating or micromanaging the child's life (e.g., inducing guilt, fostering anxiety, threatening withdrawal of love, placing a child in a double bind in which the child is doomed to fail or disappoint, or disorienting the child by stating something is true/false when it patently is not). The acts may contain emotional unresponsiveness (ignoring) and *Isolating*, with the latter being caregiver acts that consistently and unreasonably deny the child opportunities to meet needs for interacting/communicating with peers or adults inside or outside the home (APSAC, 2019).

In accord with our own assertions, APSAC's definition suggests that severe PABs reach the level of child maltreatment. The pattern of regular denigration aimed at controlling the child's access to the other adequate parent and negatively impacting their affection for that parent exploits and corrupts that parent–child's relationship. Such parental behaviors are detrimental to the welfare of children. The implication of a child's rejection of a parent in response to PABs from the other parent are without basis for physical and psychological protection and are maladaptive. This must be handled by courts and practitioners as a situation of abuse.

What is the distinction between other subtypes of FV and PABs?

As noted, PABs are problematic and harmful to children because they promote enmeshment or other problematic parenting behavior but may or may not rise to the level of child maltreatment. These behaviors deprive children of positive parenting and create conditions in which children's sense of security to both parents is undermined. Children having two (or more) secure relationships to parents is more favorable than having one or none (Sagi & Van IJzendoorn, 1996; Lamb, 2021). Moreover, when parents are in conflict and adolescents feel caught between them, they are less likely to feel close to both parents, which is associated with poor adjustment (Buchanan et al., 1991). In this way, extreme patterns of PABs are part and parcel of child maltreatment. These PABs constitute a form of coercive control perpetrated against the other parent through the coparenting relationship. For example, false allegations of FV (IPV, child maltreatment and PAB's) can create turmoil and trauma in the family and contribute to the temporary disruption or permanent loss of an adequate parent. They are also a form of coercive control because they exploit the child as a tool of the perpetrator against their other parent (Harman, et al. 2018; Drew, 2022). But sometimes the false, distorted allegations against a co-parent are evoked by paranoid beliefs or delusions that the parent cannot separate from reality; more often than not, the child cannot separate them either. The damaging outcome calls into question whether a conscious, malicious motivation is a necessary condition of perpetrating FV in all its forms. The parent's behavior must be considered as an issue of abuse regardless of intent, so that outcome/impact is given precedence over intent.

Whether PABs reach the level to constitute FV depends not only on intent, but on severity and context. Not all parental behaviors that resemble PABs are indicative of FV and some can be protective of a child and a preferred parent (Milchman, 2021). However, PABs can be part of a coercive and controlling pattern with a co-parent and/or

coincide psychological maltreatment of a child. The problem exists most powerfully in the gray zone where no dominant single factor for the child's rejection of a parent is assessed. There are no clear demarcations about when the kinds of damaging parenting behaviors inherent in high conflict divorce or separations among psychologically vulnerable parents are frequent enough, severe enough, or impactful enough that the behaviors become a pattern that slips into the red zone of PA, IPV and child maltreatment. These are the cases in which controversy festers and reproduces time and again in the family courts.

CLINICAL IMPLICATIONS FOR ASSESSMENT AND INTERVENTIONS IN PCCP CASES

Differential assessment

Adding to the challenges and controversies of asserting that PABs can be a form of FV, parental behaviors alleged to be PABs can be protective of a child (Milchman, 2022). That is, the same observable parental behaviors, such as not supporting contact with the other parent, can have different intent and impact depending on the familial context in which they occur. The extreme examples of a parent filing a restraining order or making a report of child abuse exemplifies this issue. These actions can be appropriate and necessary on the part of a parent to protect themselves and their child from FV. That same action, particularly if malicious, can have a devastating impact on the other parent's contact and relationship with their child. In fact, the intent of the parent's action may be protective or well-meaning rather than malicious and coercively controlling, but such protection can be damaging. Take, for example, the parent who misinterprets the behavior of the other parent as dangerous or abusive due to residue of their own past trauma experience or the child's distorted reports of their experience with the other parent, what happens when that parent takes action with the court based on these distortions? With the child initiating or supporting the views of the parent engaging in that behavior, a determination that the behavior constitutes PABs is more challenging to prove. Family court professionals are faced with determining these crucial distinctions in cases where a PCCP is present, but its genesis is unclear. The possible mis-assessment of what type of PCCP is occurring puts the child's welfare at risk and complicates efforts of professional help working in the family courts, thus, increasing professional risk and exacerbating the conflict. (Warshak, 2020).

An additional challenge of differentiating PABs from protective parenting behaviors is that the child's voice, which is critical to the determination of their best interests, is typically aligned with the views of the parent alleging IPV or child maltreatment by the other parent. In these cases, it is our experience that the child's voice can have a biasing impact on child protective service involvement that favors a finding of those forms of FV. Finally, child protective service investigations typically make findings of whether abuse/neglect have occurred and rarely address false allegations as PABs that are emotionally/psychologically abusive to a child. This investigative bias can result in the greater likelihood of multiple false allegations by a parent and/or "forum shopping" as they receive no negative consequences for that psychological maltreatment of the child.

An encouraging approach that assists the differential assessment of parenting behaviors that contribute to PCCPs has been provided by Madelyn Milchman (2022). The author's protocol assists in the clinical and forensic assessment of the causes of parental rejection in parenting plan dispute cases. The Multidimensional Assessment of Causes of Parent Rejection (MAP) provides a schema to assist the interpretation of data collection to help differentiate protective parenting behaviors and PABs (Milchman, 2021). The MAP model lists behaviors that have been identified as PABs in the social science literature, asking the question, "What else could cause a parent to engage in that behavior?" It encourages a deeper investigation of parental behaviors that can help discern whether a particular behavior, such as contact interference, bad mouthing, or allegations of FV by a parent are PABs or protective parental behaviors. Similarly, it encourages an investigation to interpret whether child behaviors in a specific case, (such as making allegations of abuse, providing frivolous reasons or borrowed scenarios to justify their rejection of a parent),

show complete lack of ambivalence in their negative views of a rejected parent. Further, does the child ally with the preferred parent, or respond in a disproportionately rejective way? Is the child's behavior consistent with an abuse-related response, influenced by PABs, or in response to other factors impacting the child within or outside the family system? The MAP protocol has the benefit of providing assessment guidance for each potential cause of a PCCP, it organizes them sequentially, incorporates external evidence, and makes a review of the expert's evidence more transparent by requiring the weighing of corroborating and disconfirming evidence. This assumption supports a sequential approach to assessment in PCCP cases where IPV and child maltreatment is distinguished and prioritized over PABs in all cases. That anchoring bias does not acknowledge that in some cases, PABs can be extremely harmful and traumatic to children and abusive to the perpetrator's coparent, so individual case analysis of the presence, severity, and impact of PABs (which are by definition not protective), must be integrated into an analysis, even as safety is prioritized in assessment.

A challenge in the differential assessment of PCCPs of all types, particularly where none of the forms of FV (IPV, child maltreatment and PABs) are found, determines the presence and severity of multiple factors within and outside the family system that are contributing to PCCPs. For instance, even if non-abusive, adverse parenting practices on either or both parents' part, can be harmful to children and promote resistance to contact with a parent, thus contributing to PCCPs. The determination of their severity and impact is critical to designing appropriate interventions. Some current models provide useful differentiation of aspects of family system dynamics that are relevant to assessing the severity of the PCCP and the vital importance of maintaining a "safety first" stance throughout assessment and intervention (Johnston, 2016). These assist in determinations of prognosis and implementation of appropriate legal and psychological interventions.

Measurable aspects of individual behavior (parent and child), relationship patterns (parent–child, coparenting) along with other factors internal to the family system (the health/pathology of family narratives, extended family involvement, etc.) and external to the family (adversarial court involvement, the quality and effectiveness of clinical interventions), are identified in systematic assessment models by several authors (Judge & Deutsch, 2016; Fidler & Ward, 2016; Johnston & Sullivan, 2020; Drozd et al., 2013). These multi-factor models can make the assessment of PCCPs more accurate, which can help legal and psychological interventions better fit the subtype identified (Walters & Friedlander, 2016). Drozd and colleagues have provided a stepwise sequential approach to decision-making about PCCP, which puts child and parent safety first. This guards against anchoring biases in cases that are multi-determined. Moreover, it assists with the sequencing of interventions and highlights ongoing review of the focus of goals and objectives of interventions and its effectiveness (Drozd et al., 2022).

Clinical interventions

Some IPV advocates assert that even interventions that address the subtypes of PCCPs where IPV is not the dominant factor should not be undertaken (e.g., Mercer, 2021). They make the argument that these interventions lack any scientific support of safety and effectiveness necessary to intervene responsibly and ethically. We believe that this stance is flawed for a number of reasons. First, a standard that places a threshold for clinical intervention that requires evidence-based treatment and has randomized controlled trials (RTC) of specific intervention protocols with rigorously identified samples of patients that measure safety and effectiveness before they can be employed, is an unattainable standard for virtually all existing court-involved interventions (Boaz & Davies, 2019; Greenberg et al., 2019; Pruett et al., 2021, Drozd, et.al., 2022). If this standard was applied to interventions addressing the spectrum of PCCP cases, none, including those that are currently employed to cases of IPV, would meet those standards. Further, applying this standard would preclude the development and use of interventions in social science that are already accepted in our field but have not previously been applied to family court situations. These legal and clinical interventions are usually supported by evidence-based practices from other areas of practice that are then applied to the family law population. They are "evidence-informed" treatments.

While the interventions are not evidence-based for this new application, it is a step in the right direction for learning which of them are effective with family court populations. Greenberg et al. quote that the American Psychological Association definition of evidence-based practice (APA, 2021) is "the integration of the best available research with clinical expertise in the context of patient characteristics, culture and preferences." This science-informed standard is the standard of practice for most, if not all, roles and interventions in the family justice system (Greenberg et al. 2019; Greenberg et al., 2021), including court-involved therapy, co-parenting counseling, parenting coordination, parenting plan evaluation, mediation and interventions with court-involved populations that present with trauma, interparental conflict, special needs children, substance misuse issues and FV. Though caution is prudent, including a rigorous risk/benefit analysis of intervening, prohibiting interventions for a large and vulnerable population because no evidence-base is yet established, is to make "the perfect" enemy of the good.

The development of clinical interventions specifically designed to address the spectrum of PCCPs is no exception to this common trajectory. They apply a variety of existing evidence-informed treatments, including interventions that are psychoeducational (Moran, et.al, 2019), trauma-informed (Deutsch et al., 2020), culturally informed (Harris-Britt, et al., 2021) coping or skills-based approaches such as family systems (Lebow& Reckart, 2007; Greenberg & Lebow, 2016; Faust, 2018), and child-centered conjoint therapy (Greenberg et.al, 2016).

Given the limitations and realities of research on legal and psychological interventions in the family justice system in general, responsible interventions for PCCPs should be tailored to fit proportionately to the severity and type of case. For example, unless the PABs are both determined not to be protective of the child and to have the severity of child abuse and psychological maltreatment, removing the child from the favored parent's care is not a proportionate response. Neither is intervening to protect the child in this situation as emotional harm is occurring, in which case a proportionate response at least initially, should be an evidence-informed family systems intervention (Judge & Deutsch, 2016; Walters & Friedlander, 2016).

A family-systems, strengths-based treatment model responds to the primary mission of family courts creating parenting plans that include both parents, but only after ensuring both physical protection and emotional security are in place for the child and at least one parent who can keep the child safe and secure. In fact, with the "Best Interests" of the child as the objective, principled decision-making involves pursuing four priorities in sequence: (1) protection of the child from harm, (2) security of the child's relationship with a non-offending parent, and (3) accountability and reparation of any violation of the child's lived-experience by an offending parent(s), before attempting (4) inclusion, that is reconciliation and reunification of the child with an offending parent.

There are controversies that inevitably arise from this task, as critiques of the approach assert that particular interventions cannot rely on a sufficient evidence-base to support the verification of successful practice. Yet, Johnston (2016), in reviewing the Overcoming Barriers treatment approach to situations where a child strongly and persistently resists or refused contact with one parent for little or no substantial reason states, "the approach draws upon the collective experience of well-seasoned clinicians and is informed by a wide range of research evidence and appears to be relevant to understanding and treating these kinds of problems" (p. 307). This is consistent with science-informed practice. We believe that careful analysis and grounding in evidence-based literature argues for cautious but forward movement, since "doing nothing" is usually too costly for children and families in need of immediate treatment.

Public policy implications

Two recent public policy approaches to the controversies in the family justice system as it struggles to address the challenges and complexity of PCCP cases are compared in this section. One is Kayden's Law (2022), which was a specific add-on language to the Federal omnibus funding bill called the Violence against Women Act (VAWA) of 2022. Kayden's Law prohibits funding associated with the bill for states that acknowledge Parental Alienation as part of the spectrum of types of PCCP. It is based on flawed premises which appear to originate largely from one

preliminary and controversial study (Meier, 2020; Harman & Lorandos 2021; Meier, et al. 2022) and a successful last-minute lobbying effort by a singularly focused advocacy group in Congress just prior to the bill's passage.

There are several problematic impacts of the bill's potential adoption at the state level. First, interventions that seek to address any other subtype of PCCP than those where IPV is present are precluded. The legislation further proposes that judges be prohibited from using their discretion of court-based interventions that have a goal of reunification to a rejected parent where domestic violence has been found to have been perpetrated by that parent at any time. It does not take into consideration the severity of the abuse, the impact of the abuse (precludes a trauma-informed approach), current or future safety issues, any relevant factors in the child's experience in the custodial parent's home (adverse parenting, mental health/substance misuse issues, attachment issues, etc.), and any meaningful positive changes in the abusive parent that may have occurred over time – perhaps as a result of effective treatment. Most concerning is that Kayden's Law mandates for federal funding of programs at the state level appear to extend to all child custody cases where PCCPs are present, not just those where domestic abuse is present. This ignores the huge variety and severity of cases, and contributing factors that we have detailed throughout this article.

Second, training in any topic areas relevant to PCCP other than domestic abuse is not permitted if states want funding. Not surprisingly, PABs are not acknowledged as a possible form of FV, and training in our current understanding of PA as a type of PCCP is mandated not to be included. Third, discretion of judges is limited in PCCP cases to both restrict the existing parenting time for the preferred parent, and to order interventions that address the problems in the family system. For all of these reasons, it is our view that if adopted by states, Kayden's Law will have an adverse effect—not just on cases of PA—but on all cases where families need legal or clinical interventions to address the broad range of PCCP types described in this article.

Another public policy approach was recently published in a joint statement by the Association of Family and Conciliation Courts (AFCC) and the National Council of Juvenile and Family Court Judges (NCJFCJ) (AFCC & NCJFCJ, 2022). In contrast to Kayden's Law, the statement was authored by a joint organization, multi-disciplinary task force, who took two years to finalize the statement. It was informed by a survey of 1049 members of both organizations (Pruett et al. 2023), integrated the available social science on PCCPs, and formally approved by the membership of both organizations.

The NCJFCJ/AFCC joint statement identifies some central problems in the family justice system's efforts to address PCCPs as hampered by "gendered and politicized assumptions that either parental alienation or intimate partner violence is the determinative issue" and "a lack of understanding of different perspectives, education among family law professionals and resources" (p. 1). It provides the following considerations and recommendations to family court professionals that are in contrast to the mandates of Kayden's Law and consistent with the points of this article:

1. In terms of prioritizing the safety of children and parents, "A paramount focus of practitioners working with parent-child contact problems should be to promote safety, interests, rights and well-being of children and their parents/caregivers at all socio-economic levels" Addressing the priority of safety: "Parent child contact issues, once identified, should be uniquely screened for safety and family risk factors, including the severity, frequency and impact". The risk factors identified include PABs.
2. Addressing screening and assessment in PCCP cases, the statement supports the consideration of all factors that may contribute to PCCPs, and it includes PABs in safety assessment and in professional training to effectively work with families where a PCCP exists. It notes the limitations of relying on social science in the complexities of real-world practice and stresses the importance of examining each case uniquely, to intervene in an effective, child-focused manner.
3. With regard to interventions, the statement supports when referring, recommending or ordering services and interventions for PCCP cases, that they should be proportionate, accessible and accountable.

4. Relevant to professional training, the statement includes PA in a comprehensive list of topic areas relevant to increase the competence and specialized knowledge necessary to work with PCCPs.

CONCLUSION

As if PCCPs were not complicated enough to assess and treat, the lack of conceptual clarity within the field about their subtypes is a significant problem that hinders more effective progress being made to help families facing these painful, often intractable dynamics, with devastating consequences. Since concepts are tools to guide understanding and treatment, increasing their precision is critical to their utility. This article provides greater precision in the distinctions and overlaps between subtypes of FV (IPV, child maltreatment and PA/PABs).

A multi-factor approach to assessment that guards against anchoring biases is essential to the differential diagnosis of subtypes of PCCP. This concept development can help prevent the weaponization of these concepts that frequently occurs in the legal adversarial court contexts that address these issues. We believe it will deter the concept creep that blurs distinctions so that concepts can be argued to be true and false, especially because their definitions become so broad that exceptions and variations are easily identified in every circumstance.

The data is clear: PCCPs are prevalent, harmful to children, and vexing to the family justice system. A differential assessment is critical to designing and implementing proportionate, effective legal and psychological interventions in these complex cases. If PABs are severe, they, like other forms of harmful parenting behaviors, are psychologically abusive to children and can be coercive and controlling to the rejected parent. Therefore, efforts to better differentiate parental behaviors that are alienating or protective like those described in this article are critical.

This article focuses on the definitional clarity needed to support the development of appropriate assessment and effective intervention even when complex dynamics threaten to obscure the clarity sought. Professional understanding of the overlaps and distinctions between PABs, PA, IPV, child maltreatment needs to be augmented. Public policy support of research, practice, and training on all types of PCCPs, best serve the interest of children and families in the family justice system.

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SPECIAL ISSUE ARTICLE

Defining points and transformative turns in family violence, parenting and coparenting disputes

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Abstract

Family violence is a multifaceted issue encompassing various harmful behaviors within familial relationships. This paper explores the definitional problems presented in this special issue on family violence and its impact on parenting and coparenting. By examining the shifts and expansions of concepts related to family violence over time, we highlight the transformative turns in this special issue that have helped us to clarify our understanding of family violence. We explore the transformative expansions of family violence by situating this exploration within a "concept creep" analysis. We make a note of the underlying assumptions associated with these concepts. Through an analysis of concept creep, we elucidate how the expansions and redefinition of violence-related terms have influenced our understanding of family violence. By differentiating family violence, intimate partner violence, and maltreatment, we emphasize the necessity of unpacking these terms to avoid oversimplification or overlooking certain forms of violence that may go unnoticed under narrow definitions. The authors further highlight the need for interdisciplinary collaboration to address the complexities of family violence and its impact on parenting and coparenting. By acknowledging and responding to expansions of concepts in family violence, we can strive to protect and support children in these

challenging circumstances, ultimately promoting their well-being and creating safer family environments.

KEYWORDS
child safety, concept creep, coparenting, family law, family violence, parenting

Key points for the family court community

- Family violence is a hypernym for various forms of violence and abuse that can impact intimate relationships.
- Concept creep provides a framework for understanding family violence concepts' horizontal and vertical expansions over time and its impact on parenting and coparenting.
- Due to the complexity of family violence, a systematic approach must thoroughly screen, assess and intervene to ensure the safety and well-being of all family members.
- An ecological approach to family violence emphasizes the various interrelated levels that impact and influence the consequences of violence within families.

DEFINING FAMILY VIOLENCE

Family violence is a multifaceted and complex family law issue that occurs within the intimate spaces of households, impacting individuals of all ages and relationships. Family violence is any form of abuse, maltreatment, or neglect perpetrated towards another family member, including adults and children within the family system (Department of Justice Canada, 2022). Numerous conceptual frameworks have been developed to better understand family violence by focusing on the various types, causes, and frequency (Rossi et al., 2016). Violence and abuse can occur across multiple family relationships and contexts, including intimate partner violence (IPV), child maltreatment, elder abuse, and pet abuse (Department of Justice Canada, 2022). Violence and abuse within the family system can include physical, sexual, psychological, emotional, and economic abuse. Numerous conceptual frameworks have been developed to better understand family violence by focusing on the various types, causes and frequency (Rossi et al., 2016). Differences in the context and consequences of violence can have implications for addressing safety issues within parenting plans (Drozd & Saini, 2019).

In this special issue on family violence, several definitions of violence have been proposed, focusing on intimate relationships or relationships between and among multiple family members. Nonomura et al. (in this issue) focus on legislative changes in Canada that have helped to reshape the definition of family violence to include any form of abuse within a family that provides for IPV and child abuse, including exposing children to IPV. Sullivan et al. (in this issue) define family violence as "an umbrella term" for the various kinds of violence within family dynamics, including IPV, child maltreatment and neglect, and behaviors that attempt to undermine the child's relationship with the other parent. Davis et al. (in this issue) emphasize that family violence is not limited to any specific demographic or socioeconomic group and can occur across diverse family structures.

Several recent attempts have been made to expand the concept of violence to be more inclusive of diverse family dynamics. For example, scholars have emphasized that family violence can occur within the diversity of significant interpersonal relationships, including intact and separating husband and wife relationships, girlfriend and boyfriend dating relationships, gay, lesbian, transgender and non-binary partners, parents and children, and adult children and elderly parents (World Health Organization, 2002; Huss, 2009).

By defining violence, the APA Task Force on Violence and the Family focused on patterns of abusive behaviors (e.g., physical, psychological, emotional, sexual, economic) that are used to gain power over the other, maintain the misuse of power, and control the other (as cited by Rakovec-Felser, 2014). Hardesty et al. (this issue) emphasized behaviors in intimate relationships that cause physical, sexual, or psychological harm based on the World Health Organization (WHO, 2022) but also noted the importance of distinguishing coercive controlling violence (CCV) from situational couple violence (SCV). Rossi et al. (this issue) relied on a definition by Breiding et al. (2017). This definition focuses on IPV and describes it as physical or sexual violence, stalking, psychological aggression, or coercion by a past or current intimate partner.

O'Leary (in this issue) suggests that no single agreed-upon classification system defines family violence. Rather than illustrate violence or abuse, Ponting et al. (in this issue) focus on the risk factors associated with the risk of violence. O'Leary (in this issue) focuses on the association between family violence and substance misuse. Davis et al. (in this issue) emphasize the role of judicial decision-making when family violence is a factor in determining parenting time and implications related to remote technologies.

In summary of the articles in this special issue, it can be postulated that the complexity of family violence arises from various factors, such as power imbalances, societal norms, cultural influences, and individual characteristics (Hardesty & Ogolsky, 2020), but, as Davies (in this issue) noted, the consequences of family violence extend beyond immediate harm, permeating the emotional well-being, relationships, and overall functioning of individuals and entire family systems, including, more specifically, the impact on parenting, coparenting, and child adjustment.

Ponting et al. (this issue) also point out that there remains little consensus regarding a universally accepted definition of children's exposure to IPV. Family law has moved from describing a "child witness of violence" (Aitken, 1998) to a "child exposed to violence" (Holden, 2003) to better reflect the different types of violence children experience beyond simply observing the violence. Holden (2003), for example, suggests other forms of exposure, including prenatal exposure, victimization, participation, eyewitness observation, overhearing, observation of the initial effects, experiencing the aftermath, and hearing about the violence. Ponting et al. (this issue) encourage the broad definition of children's exposure to IPV as the more inclusive approach. This broad definition of children's exposure to IPV is consistent with the United Nations (UN) Convention on the Rights of the Child, which has recognized that children should be protected from harm and that they have a universal right to live free from all forms of violence (Convention on the rights of the child, 1989, Article 19).

THE ROLE OF LANGUAGE AND LABELS IN PERCEPTIONS OF VIOLENCE

Language and labels are crucial in shaping perceptions of violence and abuse within society (Wilcox, 2008). How we conceptualize, describe, and label acts of violence and abuse influences how we perceive and respond to them. Language reflects societal attitudes and values and has the power to shape and reinforce those attitudes (Rakovec-Felser, 2014). The use of language can either normalize or condemn specific acts of violence and patterns of abuse. Descriptive and accurate language of violence and abuse can convey the gravity and harm of these violent acts, bring awareness to acts of violence, and foster a sense of urgency for addressing the issue. In contrast, euphemistic or dismissive language related to violence can downplay the severity of an act of violence and deny harm's impact on individuals (Walker et al., 2021).

Labels attached to different forms of violence and abuse impact how we understand and respond to perceptions of harm. Specific labels, such as domestic abuse, IPV, or child maltreatment, not only categorize and differentiate

various types of violence but also highlight the particular dynamics and contexts in which they occur (Walker, 1999). Language and labels also influence perceptions of "victims" and "perpetrators" (Wilcox, 2008). The terms used to describe individuals involved in violent incidents can shape societal attitudes towards them. Victim-blaming language, for example, can perpetuate harmful stereotypes and shift the focus onto the victim (Clark, 2021), hindering support and empathy towards victims and contributing to the underreporting of violence (Heckert & Gondolf, 2000).

MOVING TOWARDS INCLUSIVE LANGUAGE GUIDELINES REGARDING FAMILY VIOLENCE

In 2021, the American Psychological Association (APA) issued *Inclusive Language Guidelines* to be used in conjunction with the *American Psychological Association Publication Manual, 7th edition* (2020). The Guidelines were developed to further equity, diversity and inclusion (EDI) by using language that fosters inclusivity, respect, and safety in all environments (American Psychological Association, 2021). The Guidelines focus on marginalizing and harmful words and person-first versus identity-first language, emphasizing the person's choice of defining their identity rather than allowing others to define the person by their chosen label.

Consistent with these Guidelines and wanting to raise awareness of the possibilities for change and address marginalization and stereotypes that accompany experiences such as family violence, we asked the authors of the papers in this Special Issue to use inclusive language consistent with these guidelines. Specifically, we asked them to avoid terms such as victim and perpetrator, instead using a person who experienced or has been impacted by violence and who uses violence. Through these language changes, we could also focus on the actual impact of family violence on factors such as parenting, coparenting and child adjustment, as well as evidence-informed interventions that take into consideration an ecological perspective and the ripples of effect from the individual to the family system to the community.

CONCEPT CREEP: EXPLORING SHIFTING DEFINITIONS

Language and labels are not static. They evolve as societal attitudes change and knowledge grows (Rakovec-Felser, 2014). As our understanding of violence and abuse expands, the language and labels must reflect these advancements. Regular evaluation and terminology revision are necessary to ensure they accurately represent changing societal trends. For example, cyber abuse, cyber harassment, and cyber stalking are recent expansions of the concepts of violence to address the virtual interactions among family members and the increased dependence on technology for communication and social connection. Another example is the concept of cyberbullying, which was expanded from the idea of bullying (Mishna et al., 2012).

While these expansions of harm can be considered both normal and positive evolution of concepts based on changing societies, we must also be mindful of the potential negative impact of increasing notions of harm. The term concept creep was first described by Haslam (2016) in psychology as a framework for understanding the growing expansion of harm-related terms (e.g., the inclusion of cyber abuse as an expansion of the concept of violence and abuse). Haslam et al. (2020) suggested that while expanding concepts of harm can identify new forms of harm previously unrecognized, broadening definitions also have the danger of diluting or even changing the meaning of original concepts. Concept creep has helped shed light on previously overlooked forms of violence within families (e.g., emotional harm, cyber abuse, legal abuse), drawing attention to how individuals can experience harm within intimate relationships. Recent conceptual frameworks have isolated, for example, coercive and controlling dynamics to safeguard against these most devastating forms of violence. Hardesty noted (this issue) that different forms of violence and abuse would likely require different interventions to address the unique factors of the various forms of violence and abuse.

The Wingspread conference (Ver Steegh & Dalton, 2008) provided the opportunity to consider the expanding forms of violence and abuse that impact families in the context of family law (Jaffe et al., 2008). It helped to bring attention to these expansions by situating them within a classification schema that includes the different forms of violence and abuse, including Coercive Controlling Violence, Violent Resistant, Situational Couple Violence, and Separation-Instigated Violence (Jaffe et al., 2008; Kelly & Johnson, 2008).

Austin and Drozd (2012) created an integrated conceptual framework for the expansion of violence and abuse concepts in the context of parenting plan disputes, in which they urged parenting plan evaluators to approach assessment using a systematic method for considering the following:

1. Risk factors (e.g., history of previous violence, substance misuse, major mental disorders, and threat assessment factors).
2. Kind of aggression (e.g., physical, emotional/psychological, and coercive control).
3. Pattern, frequency, severity, and the nature of the child's exposure.
4. Pattern of instigation (e.g., primarily male, primarily female, mutual, defensive or reactive, involving multiple instigators).

By focusing on the expansions of concepts on a continuum, the Austin and Drozd (2012) conceptualization emphasizes the value of considering violence-related factors by assessing violence's patterns, frequency, and severity instead of focusing just on categories. This approach facilitates a comprehensive assessment of violence and abuse that integrates the fit between the unique experience of each family member and the effect of family violence more broadly on the children, parenting, and coparenting. Connecting assessment plans to parenting plans is essential, given the little attention in the social science research that connects the various forms, patterns, and contexts of violence to preferred parenting plans for optimal safety and well-being among family members.

As our understanding of the risks, consequences, and impacts of violence and abuse has evolved, new terms and concepts have been added to include the expansion of harm. As mentioned above, violence and abuse have expanded to include cyber abuse within a family or intimate partner relationship. Cyber abuse typically involves using digital technology, such as smartphones, social media, email, or other online platforms, to harass, threaten, control, or intimidate a family member or intimate partner. This type of abuse can take various forms, including sending threatening or derogatory messages through text, email, or social media to a family member or partner; using technology to track the victim's online activity, location, or movements without their consent; sharing explicit or intimate images or videos of a family member or partner without their permission, often with the intent to humiliate or harm them; manipulating or controlling a partner's online presence, such as forcing them to share passwords or monitoring their online interactions; engaging in cyberbullying behavior within a family context, where one family member bullies or harasses another using digital means; pretending to be the victim online and posting false information or making false statements to harm their reputation or relationships; or using technology to isolate the victim from friends and family by controlling their access to social media or communication platforms (Al-Alosi, 2017). Cyber abuse can have severe emotional, psychological, and even physical consequences for the victim, violating their privacy and personal boundaries (Woodstock et al., 2000).

Hardesty (this issue) also highlights the recent trend towards expanding the concept of coercive control to include "legal abuse" as a form of violence that intentionally misuses the court processes to continue to control former partners (Gutowski & Goodman, 2023). Hardesty (this issue) suggests that examples of legal abuse can include prolonging litigation with frivolous motions, forcing in-person contact at court, seeking full custody to retain control, making false allegations of abuse to gain an advantage in a legal dispute and portraying a parent as unfit or hostile to gain a tactical advantage in the court. Legal abuse can have significant emotional, psychological, and financial consequences for those impacted by violence.

Another example of the suggested expansion of violence is found in the paper by Sullivan et al. (this issue), in which they seek to include severe parental alienating behaviors (PABs) as a form of family violence. While highly

controversial, the authors make a compelling argument for expanding concepts of violence to include the most severe behaviors that could potentially cause harm to the child, including cognitive processing, physical health, emotional regulation, and interpersonal relationships. While the authors limited their focus to severe PABs, there is the risk that others will expand the definition of family violence to include all PABs, thus diluting the severity of other violent acts (e.g., IPV) or blurring the boundaries between different types of harm (Haslam, 2016). Not all behaviors identified within the grouping of PABs would be considered violent. For example, while there tends to be general support in the literature that denigrating a parent is psychologically harmful (Hibbard et al., 2012), not all of Baker and Fine (2013) documented 17 parental alienating behaviors would fit within current definitions of violence and/or abuse. For example, asking the child to refer to a step-parent as "mom" or "dad" may not be optimal or even appropriate, but it would be semantic inflation to suggest that this is abusive. Baker and Fine (2013) explained that "taken together, the 17 parental alienation strategies work to create psychological distance between the child and the targeted parent such that the relationship becomes conflict-ridden" (p. 94), and these form the concept of PABs.

The broadening of violence to include PABs has the potential to inflate the occurrence of parent–child contact problems, making it more challenging to effectively assess, identify, and address specific forms of violence. One of the risks of including PABs under the family violence umbrella is that doing that may be and is likely to be used as a weapon in the all-or-nothing war between abuse and alienation, as those on the extremes use words to weaponize their arguments that further divide us. It may also lead to variations in interpretations and inconsistencies in applying interventions and legal responses. Including PABs also has the risk of treating all forms of violence as the same, diminishing the impact of IPV or child maltreatment when the types, patterns, severity, frequency, and impact on the child's development and functioning of the PABs are not considered. Moreover, given the current adverse political climate between extreme advocates and the false binary causal pathways of parental alienation or intimate partner violence on PCCP, and semantic inflation of PABs as a form of family violence may thus result in the definition being intentionally, even maliciously, exploited in courtrooms and legislatures, potentially causing even greater harm and confusion among practitioners, policymakers, and researchers.

To navigate the potential risks of concept creep, it will be necessary for family law professionals to carefully screen for the types and patterns of behaviors that could be harmful and to be clear on the use of terms so as not to inflate harm or to silence the importance of safety and protection from harm.

With all these new and emerging trends towards expanding concepts of violence and abuse, it is essential to balance inclusiveness and clarity. Continual dialogue, research, and refinement of definitions are necessary to ensure that the expanded understanding of violence and abuse remains grounded in empirical evidence, cultural context, and the experiences of those affected. Exploring shifting definitions due to concept creep enables us to better understand the complexity of violence within family settings. It prompts us to critically examine the evolving nature of violence and its manifestations, encouraging a comprehensive approach to addressing and preventing violence in all its forms.

TOWARDS DEFINITIONAL CLARITY: CHALLENGES AND IMPLICATIONS

Defining violence and abuse presents challenges due to the overlapping categories and blurred boundaries between different forms of violence. Often, acts of violence and patterns of abuse do not neatly fit into a single category, making it challenging to capture the full complexity of abusive behaviors (Drozd & Saini, 2019).

Addressing the overlapping categories and blurred boundaries within family violence is essential in navigating the challenges of definitional clarity. Hardesty (in this issue) points out that most of the literature fails to carefully distinguish types of family violence in favor of a broad definition of violence. They suggest that each form of violence and abuse should be carefully considered, given that various forms of violence and abuse can be harmful, even if they are understood differently within the context of these forms of violence. Rossi et al. (in this issue) affirm that it is critical that separating or divorcing parents be assessed for a history of family violence and ongoing safety concerns.

To achieve definitional clarity, it is crucial to consider the importance of contextual understanding and intersectionality (Cardena, 2023). Crenshaw (1989) coined the approach to understanding family violence by recognizing structural sources of inequality as intersectionality. This approach poses that people's identities (i.e., race, class, sex, and gender) interact with systems of oppression to create unique experiences (Collins, 1998). As a result, researchers recognized the overlapping oppressions individuals of diverse backgrounds face and their impact on their IPV experiences (Sokoloff & Dupont, 2005). Family violence occurs within a social and cultural context, shaped by various factors such as gender, race, class, and sexual orientation. These intersecting identities influence the experiences of people who experience violence and those who use violence. A comprehensive understanding of family violence requires acknowledging these intersecting factors and recognizing that the manifestations and impacts of violence can differ based on an individual's unique circumstances.

Expanding definitions of family violence can have significant consequences, including underestimating and overestimating the prevalence and impact of family violence in individual cases and inadequate responses from the family law system. For example, scholars have criticized family law professionals (e.g., judges, mediators, parenting plan evaluators) for their lack of awareness and sensitivity to family violence issues, their overall lack of competency to detect family violence, and the limited use of procedures to screen for the potential presence of family violence (Ellis & Stuckless, 2006; Frederick, 2008; Hardesty et al., 2012; Ver Steegh et al., 2008). Rossi et al. (in this issue) note the consequence of practitioners lacking sufficient education on conducting family violence screening assessments, being able to interpret the results (Frederick, 2008; Saunders et al., 2011), and deciding which IPV tools to use in their practice. Given evolving concepts of violence and abuse, family law practitioners who are not receiving sufficient education about the expanding ideas of violence can provide their clients with outdated information.

Family law practitioners have also been criticized for not fully understanding and assessing the consequences of children's exposure to family violence when suggesting parenting plans to the courts (Jaffe et al., 2003; Rossi et al., this issue; Saini et al., 2019). Saini et al. (2013) found that the other parent made almost a third of family violence allegations reported to child protection services within parenting plan disputes. However, only a minority of these allegations were considered maliciously fabricated. Therefore, family law practitioners should avoid quick judgments about the complexity of these cases and not assume allegations are false. Similarly, it is essential for family law practitioners not to assume that allegations are true simply because they are reported (Drozd & Saini, 2019). Thus, family law practitioners should check any biases and collect, analyze, and synthesize data systematically and methodologically (AFCC, 2016; Rossi et al., this issue).

Section three of the AFCC IPV Guidelines (2016) suggests that a parenting plan evaluator should have in-depth knowledge of family violence's nature, dynamics, and impact. The guidelines state, "Because intimate partner violence frequently occurs in custody-litigating families and because it may be unidentified and difficult to detect, a custody evaluator will inevitably be involved in cases where intimate partner violence is or becomes an issue" (AFCC, 2016, p. 6). If an evaluator lacks knowledge in any area, the evaluator should seek relevant training, supervision, or professional consultation. We argue that all family law practitioners should receive adequate training and support to best work with the complexity of family violence. With changing and expanding definitions of violence and abuse, even those who were/are well trained might not be for long as the definitions and politics related to them are fluid. Moreover, simply using the term IPV or family violence without defining the nature, the context, and the implications fails to bring sufficient clarity required for labeling diverse forms of violence and abuse.

USING A SYSTEMATIC APPROACH

In 2016, the AFCC collaborated with the National Council of Juvenile and Family Court Judges (NCJFCJ) and, in consultation with the Battered Women's Justice Project (BWJP), to develop Guidelines for Examining Intimate Partner Violence for parenting plan evaluators, aiming to identify better the risk of family violence and its potential effects on children, parenting, and coparenting. While these guidelines were developed specifically for parenting plan evaluators, they promote a systematic approach relevant to all family law practitioners.

The Guidelines (2016) advocate for a systematic approach to evaluating family violence allegations in the context of family law disputes, considering each family's unique circumstances. It emphasizes the importance of approaching each case without preconceived biases about the impact of violence on children and parenting. The Guidelines suggest that family violence be independently analyzed, separate from other issues like mental health or substance abuse, focusing on its context and implications for safety, parenting, coparenting, and child well-being.

Adhering to this systematic approach has several benefits. It enhances the quality and accountability of the screening process, making the assessment of family violence more valuable to the parties involved and the court (Austin & Drozd, 2012; Drozd & Saini, 2019). It also prevents the imposition of the family law practitioner's assumptions, biases, or beliefs. Additionally, employing this approach can highlight any misapplication of dominant cultural norms related to family violence. The systematic approach also provides a framework to identify expanding forms of violence and abuse and clarify how these concepts apply to individual cases.

APPLYING THE ECOLOGICAL FRAMEWORK

Adhering to this systematic approach also fits with the ecological framework (Bronfenbrenner, 1979). The ecological framework highlights the interaction between human characteristics, personal development, and the environments in which individuals find themselves. Belsky (1980) and Cicchetti and Rizley (1981) expanded the ecological framework including four interconnected parts: macrosystem (culture), ecosystem (community), microsystem (family), and ontogenetic development (individual) (Belsky, 1980). By considering the multiple levels of influence within the ecological framework, including individual, relationship, community, and societal factors, evaluators can better understand the dynamics and complexities of family violence for a specific family (See Figure 1).

Identifying the ecology of violence and abuse can also assist in clarifying expanding concepts of harm by considering the interconnected parts and their interactions to investigate the etiology of violence and abuse, its influences, and the various factors that may be related to the presence of harm. The ecology of violence framework further assists in avoiding premature closure of a singular label or violence but instead urges for a systematic and comprehensive assessment of the various interactions that impact the severity, frequency, nature, and type of violence or abuse.

Applying the ecological framework in parenting plan disputes involves a comprehensive assessment and identification of family violence within the ecological context. Through a systematic approach, we can uncover the multifaceted factors that influence parenting behaviors and outcomes in the context of family violence.

Ontogenetic development (individual-level factors)

At the individual level, parental attributes, mental health, and substance misuse issues can all play a significant role in parenting plan outcomes in family violence cases. Research suggests that parents with a history of using violence against their family members tend to exhibit higher levels of anger or aggression, are more likely to struggle with mental health issues, and have higher rates of post-traumatic stress disorder (Karakurt et al., 2019). O'Leary (this issue) points to the high correlation between alcohol misuse and IPV, highlighting the consequences of substance misuse, such as alcohol or drug addiction, and the impact of substance misuse and IPV on parenting and child maltreatment.

Microsystem (relationship-level factors)

Co-parenting dynamics and parental conflict are important relationship-level factors influencing parenting plan outcomes in family violence cases (Hardesty, this issue). As Hardesty (this issue) noted, high coercive control or power imbalances can significantly impact coparenting dynamics. Protective factors, willingness to engage in therapeutic

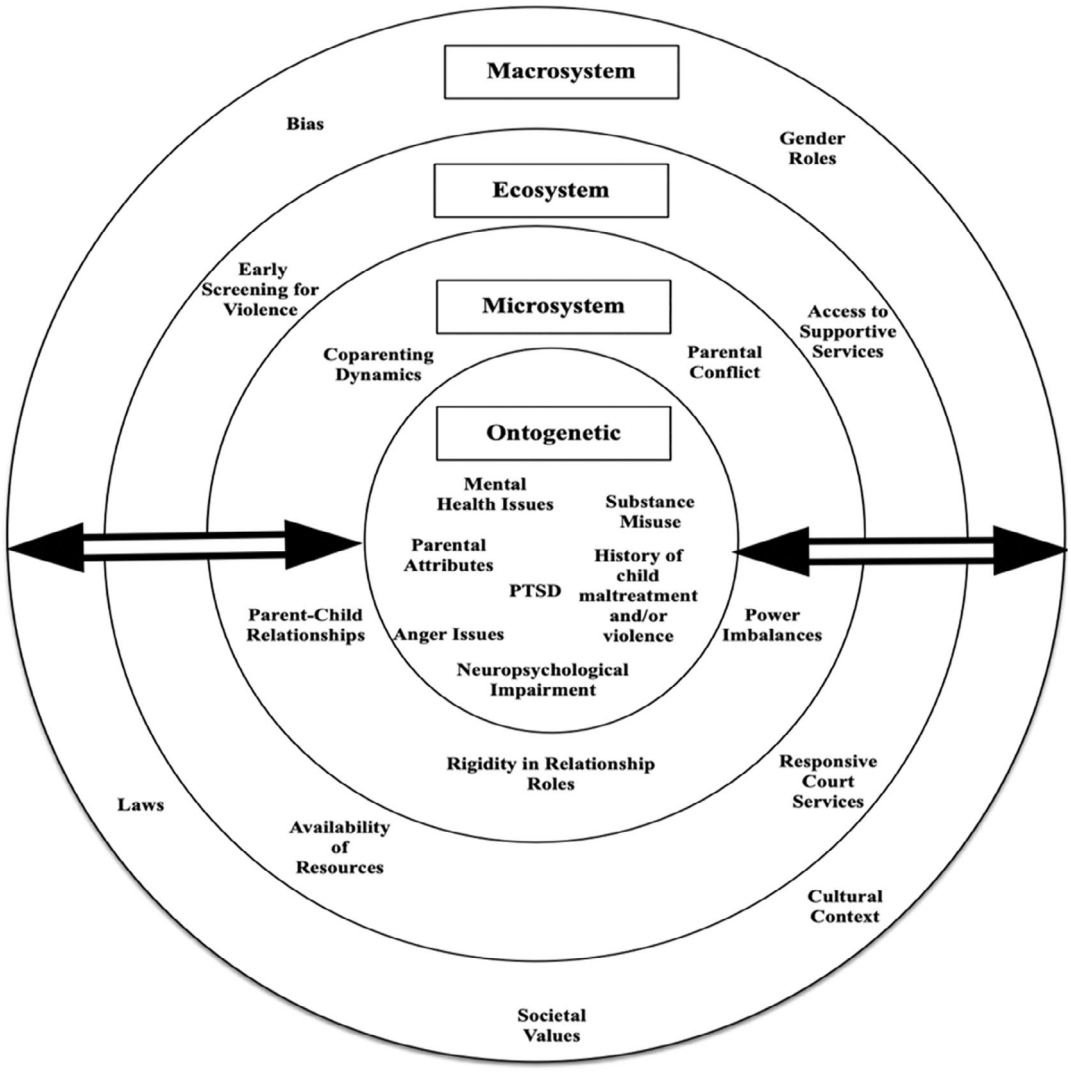

FIGURE 1 The ecology of family violence.

interventions, and demonstrated ability to prioritize the child's well-being can positively influence parenting plan outcomes. Ponting et al. (this issue) have described the potentially devastating consequences of exposure to IPV for young children, affecting the young child's neurological, relational, behavioral and physiological systems.

Exosystem (community-level factors)

Community-level factors, including the availability of resources and support services, also play a role in parenting plan outcomes in family violence cases (Davis et al., this issue). The adequacy of community resources such as shelters, counseling services, and supervised visitation programs, can impact the safety and well-being of parents and children affected by family violence. Davis et al. and Nomura et al. (this issue) describe the efficacy of anti-violence programs for fathers. Fathers can engage in these programs proactively or reactively, focusing on the safety of the mothers and their children and taking accountability through the courts.

Macrosystem (societal-level factors)

The macrosystem refers to societal factors that influence and contribute to family violence. These factors are broad and encompass the cultural, social, economic, legal and political influences within society that can either perpetuate or mitigate family violence, including societal norms and beliefs about gender roles, power dynamics, the responsiveness of the justice system, and the broader political and cultural climate. Davis and Crain (this issue) describe identity abuse in the LGBTQ+ populations as coercive control, capitalizing on societal attitudes towards these communities.

Understanding these factors at various levels within the ecological framework is crucial for professionals involved in parenting plan cases impacted by family violence. It allows for a comprehensive assessment of the complex dynamics at play and informs decision-making processes to ensure the safety and well-being of children in these challenging situations.

CONCLUSION

Exploring the various frameworks and models for understanding family violence has been a valuable exercise for this special issue on family violence and its effects on children, parenting, and co-parenting issues. This process has provided insights into the various dynamics, impacts, and risk factors associated with violence within family settings. This special issue has also offered the opportunity to critically examine the strengths and limitations of the proposed models, approaches, and interventions. Advancing definitional clarity is crucial for addressing the complexities of family violence. Family law practitioners must critically evaluate and redefine existing definitions and frameworks to ensure they capture the breadth of harmful behaviors. This includes recognizing emerging forms of violence, adapting to changes in societal dynamics, and accounting for the unique experiences of marginalized populations.

Definitional clarity should be accompanied by ongoing dialogue and collaboration among family law practitioners and researchers to ensure that definitions are meaningful, relevant, and inclusive. We can enhance our understanding of family violence by critically examining existing frameworks and models, integrating multiple perspectives, and advancing definitional clarity. This approach allows us to address the limitations of current approaches, consider the intersecting factors that contribute to violence, and develop more effective strategies for prevention, intervention, and support. Ultimately, striving for a comprehensive understanding of family violence is crucial for creating safer parenting plans for the parents and children involved in these family law disputes.

Differentiating family violence at the individual level of analysis

By recognizing the need to differentiate and address different types of violence, particularly within the context of parenting, family law practitioners can better promote safety, protection, and healthy parenting practices for the specific individuals involved.

Enhancing training and education for family law professionals

To effectively address family violence in the context of family law disputes, there is a need to enhance the training and education of family law professionals. Providing comprehensive and ongoing training on the dynamics of family violence, the impact of macrosystem variables on the availability of resources for identification and interventions, trauma-informed practices, and the impact on children, including the impact of parent–child contact problems, as well as the effect of family violence on parenting and coparenting can better equip professionals to recognize and respond to these complex cases.

Embracing interdisciplinary perspectives

Family law practitioners (judges, lawyers, mediators, parenting plan evaluators, parenting coordinators, court-involved therapists, etc.) must work together to advance our knowledge of family violence and develop a comprehensive framework for addressing family violence in the family courts. This includes embracing interdisciplinary perspectives, engaging in ongoing dialogue, and prioritizing the safety and empowerment of family members.

Consider evidence-informed approaches for addressing family violence

Addressing family violence requires a comprehensive and evidence-informed approach considering the complex interplay of individual, family and societal factors. Several strategies and approaches have been suggested in this special issue, including the development of resources and tools to address the use of technology for harassment, stalking, and abuse and to enhance digital safety for people who have experienced violence (Davis et al., this issue), the inclusion of screening (Rossi et al., this issue), early intervention (Ponting et al., this issue) and novel treatment approaches to end the escalation of violence (Scott et al., this issue).

IMPLICATIONS FOR PRACTICE AND POLICY

Navigating labels and achieving definitional clarity is essential to understand family violence comprehensively. Through this understanding, we can promote prevention, support survivors and work towards a society free from violence. By recognizing the complexity of violence within family settings and taking action to address it, we can strive towards building safer and more nurturing environments for individuals and families.

Legal interventions are crucial in creating a safe environment for families experiencing various forms of family violence. This may involve implementing protective orders, restraining orders, or parenting plans that prioritize the safety and well-being of the affected individuals, particularly children (Hardesty et al., this issue).

Clinical interventions are equally important in promoting healing and building resilience within the family system (Greenberg et al., 2019). Clinical interventions can provide a supportive and empowering space for individuals affected by family violence to process their experiences, develop coping mechanisms, and strengthen their resilience (Scott et al., this issue).

A collaborative approach between legal and clinical professionals is vital to ensure a comprehensive and coordinated response to family violence in the context of family law disputes. By working together, family law professionals can share information, expertise and resources to develop integrated interventions that address family violence's legal, emotional, and psychological dimensions within a systematic approach that embraces the complete ecology of family violence.

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ASSOCIATION OF FAMILY AND CONCILIATION COURTS

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NATIONAL COUNCIL OF JUVENILE AND FAMILY COURT JUDGES

AFCC AND NCJFCJ
JOINT STATEMENT ON PARENT-CHILD CONTACT PROBLEMS

Problem Statement:
The vast majority of separating and divorcing parents maintain safe, healthy, and positive relationships with their children; however, a small percentage of parent-child relationships remain strained and/or problematic. Children are at greater risk when parent-child contact problems are not effectively addressed and when family law professionals and others echo and intensify the polarization within the family. This problem may be exacerbated by (1) gendered and politicized assumptions that either parental alienation or intimate partner violence is the determinative issue; (2) contradictory rhetoric about the application of research findings and the efficacy of interventions; (3) indiscriminate use of services; and (4) a lack of understanding of different perspectives, education among family law practitioners, and resources.

AFCC and NCJFCJ support transparent, informed, and deliberate dialogue and response to parent-child contact problems following separation and divorce, or when the parents have never resided together, by adhering to the following considerations:

1. Adopt a child-centered approach
Children's behavior should be considered in the context of what is normal for a child's age, developmental stage, and the family socio-cultural-religious norms. This behavior may also be an expectable, adaptive reaction to stress, change, or an adverse childhood experience. The paramount focus of practitioners working with parent-child contact problems should be to promote the safety, interests, rights, and wellbeing of children and their parents/caregivers at all socioeconomic levels. Children should have the opportunity to express their views in family justice matters that concern them. The stated views of children are not necessarily determinative of their best interests. There are multiple factors that may contribute to children expressing views that do not reflect their best interests. Family justice practitioners should understand the basis for the child's expressed wishes and acknowledge their rights.

2. Increase competence in working with parent-child-contact problems
Specialized knowledge and skill are necessary to work effectively with families with parent-child contact problems. Family law practitioners should receive regular and ongoing training on the various factors related to parent-child contact problems including, but not limited to intimate partner violence, substance misuse, high conflict, denigration, parental alienating behaviors, and healthy parenting.

3. Screen for safety, conflict, and parent-child contact problems
In addition to initial and ongoing screening for safety, intimate partner violence and power-imbalances within families in all family law cases, parent-child contact issues, once identified, should be uniquely screened for safety and family risk factors, including the severity, frequency, and impact. Practitioners should, in all cases, employ a structured and evidence-informed screening for family risk factors.

4. Fully consider all factors that may contribute to parent-child contact problems
There should be no immediate label used for parent-child contact problems as there are multiple factors and dynamics that may account for these issues. These include interparental conflict before and after the separation, sibling relationships, the adversarial process/litigation, third parties such as aligned professionals and extended family, a lack of functional co-parenting, poor or conflictual parental communication, child maltreatment, a response to a parent's abusive behaviors, the direct or indirect exposure to intimate partner violence, parental alienating behaviors, an alignment with a parent in response to high conflict coparenting, or a combination of these factors. Therefore, practitioners should maintain a broad lens and sufficiently consider the relative contribution of each potential factor before conclusions are made about cause.

5. Conduct individual case analysis
Social science research findings can provide the field with valuable information about the group studied but cannot be used to determine the characteristics or experiences of individual parties or children; therefore, each family/case/situation must be specifically examined and informed by the best available evidence. Each case must be examined uniquely to understand the etiology and current dynamics of the problem for the family justice system to intervene in an effective child-focused manner.

6. Refer to appropriate and proportional services and interventions
Practitioners should exercise care in recommending, referring, or ordering family members to services and interventions. These services and interventions should be accessible, accountable, proportional to the nature and severity of factor(s) contributing to the parent-child contact problem(s), particularly when there is a court order requiring such services and interventions. Such services and interventions should be informed by a child-centered approach.

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SPECIAL FEATURE

Conclusion: Mental health and legal responses to the adolescent mental health crisis: Raising the bar on best interests and promoting family connectedness in divorcing families

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Abstract

We are currently facing an unprecedented increase in adolescent mental health problems resulting in alarmingly high levels of depression, anxiety, and suicidality. Significant mental health problems among youth pose unique challenges to families in the process of separation and divorce, as well as to family law professionals across all disciplines. The current adolescent mental health crisis calls for new ways of approaching our work with high conflict families to promote family connectedness and shift away from adversarial approaches that may exacerbate conflict and further destabilize families. As a conclusion to the special issue on adolescent mental health needs, the authors make multidisciplinary best practices recommendations and advocate for systems level changes in recognition of the needs of youth in crisis at this pivotal developmental stage.

KEYWORDS
adolescent, best practices, family law, high conflict, mental health

Key points for the family court community

- Mental heath crises among adolescents and families require newer and advanced education regarding adolescent mental health for legal and mental health professionals.

- Current mental health issues among adolescents complicate family court responses and sometimes deflect from the family systems problems.
- The current crisis calls for an increased focus on careful assessment and conflict resolution in all professional roles.
- Professinals also must reach beyond coparenting conflict to assist with the family's commitment to retaining connection through the process of divorce and beyond.
- Conflict-reduction can be better supported by an equal focus on building positive coping skills, attitudes and strategies.
- Needed shifts in intervention require training in interdisciplinary teams, using case examples to foster collaborative skills.
- We recommend redefining the roles of mental health professionals so they are bounded, explicit, and supportive of family autonomy, with reduced susceptibility to being coopted into the adversarial divorce system.

INTRODUCTION

This special section took a turn from the usual scholarly directions of FCR to focus explicitly on legal and mental health professionals' perspectives of the mental health crises facing today's youth. The section editors, Dr. Amy Wilson and Dr. Marsha Kline Pruett, proposed to identify key issues and explore barriers and everyday practices with youth and their families from perspectives of various roles in family law, with the intention of inspiring workshops, research, and interventions that respond to this unusual crisis point in societal history, and by default, in family law. While depression and anxiety are the most recognizable mental health problems we face, the authors in this section identified issues that move beyond depression and anxiety, adding important detail to the general mental health problems discussed in lay literature and scholarship. These commentaries and articles provide a clearer picture of what professionals of all disciplines need to watch for, assess, and help families manage on their own or through therapeutic resources and family law interventions. They also suggest promising practices that offer hope and practical suggestions for professionals working with these youth in great pain, and their families.

PROFESSIONAL PERSPECTIVES AND RECOMMENDATIONS

Professional perspectives regarding the youth mental health crisis reveal diversity across roles, yet consistency in terms of shared concerns. **Pasternak and Montgomery**, **Ajoku**, and **Mitnick** share their "reports from the front lines" in the roles of therapist, parenting plan evaluator, and parenting coordinator. The challenges they articulate include sharply increased suicidality among teens, difficulty obtaining mental health services for their clients, and

the need for validated assessment and evaluation techniques in response to increased complexity and fragility in the family system, exacerbation of high–conflict struggles that manifest -for example- in parent–child contact problems, and an overall intensification of the most challenging aspects of our work as family law professionals. Adolescents are struggling not only within their families, but also socially and culturally as they strive to adjust to returning to school, extracurricular activities, and a society at large that is still reverberating from the impact of the pandemic and evolving social mores that offer more choices and less direction in terms of identities and behaviors. Teens, and the professionals who work with them, are carrying a load that is unprecedented in both its weight and complexity.

These authors paint a picture of a family court system in which the stakes are higher than they were previously. In effect, adolescent mental health issues serve the function of "heating" the family environment at the very time that the family is needing to quell the flames. However, we, as family law professionals, have the responsibility and the tools to help keep the systems cool. To do so effectively may require a reexamination of our standard ways of operating. That is, the traditionally adversarial system of family law may be creating a precarious environment for adolescents in crisis.

O'Brien and colleagues artfully challenge us to consider that adolescent mental health can become a "red herring" in high conflict cases, shifting focus away from parental conflict and poor coparenting and causing professionals to miss the important opportunity to recognize the deleterious impact that acrimonious coparenting has on children. This is a warning for professionals to stay focused on family systems approaches to high conflict cases, rather than allowing the child to become the "identified patient" in a dysfunctional system being driven primarily by parents in intractable conflict.

In some cases, however, adolescent mental health is not a red herring, but the central issue of concern that requires careful consideration by legal professionals and the courts. Children are being hospitalized for suicidality, entering residential treatment and wilderness programs in record numbers, and frequently returning home in a fragile state (e.g., Gutierrez-Sacristan et al., 2022). This often occurs within the context of pre-existing high conflict coparenting, parent–child contact problems, and other family systems dynamics that make reentry challenging for the family. Additionally, parents may differ in terms of their availability to monitor and provide parental care to the adolescent. In some cases, reconsideration of the custodial schedule and/or parenting plan is warranted, even if only on a temporary basis. Sometimes parents can agree to such a change, perhaps with the help of a parenting coordinator or coparenting specialist, but this situation can create a "perfect storm" that results in the family regressing to a high level of interparental conflict that makes decision-making and conflict resolution intractable. In such cases, court intervention may be warranted to protect the adolescent during this fragile period.

Greenberg and colleagues address such situations in which the child's health concerns are at the center of the family crucible in which children and adolescents have physical and/or emotional vulnerabilities. Even when a physical or mental illness is the primary concern for parents, the adolescent's condition can be significantly impacted by parental conflict directly (e.g., through the child witnessing the conflict or experiencing the lack of consistency in caregiving) and indirectly (e.g., through parental mismanagement of the condition due to parental disagreement and associated struggles related to interfacing ineffectively with the medical professionals involved). In this way, the relationship between adolescent mental illness and coparenting conflict is bidirectional, rather than linear, with each domain fueling the other. The authors highlight the fact that interventions focused on increasing coparenting collaboration are crucial to assisting teens and families in coping effectively and navigating treatment needs productively.

Sometimes situations involving teen mental health crises actually serve to bring parents together. Crisis can potentially shift parents into a deeper sense of commitment to a functional coparenting relationship, ending old patterns of bitter conflict and disconnection. Family members such as stepparents and grandparents may alter their prior unhappy stances and positions to create a healthier family environment for a child in crisis. While it would be naïve to assume such a response will emerge without significant support, a "jaded" view born of years of dealing with high conflict cases can lead us to miss the opportunity to bring a family together around the needs of an adolescent. In

such cases, the adolescent and his/her needs for stability can become a unifying theme for family members and professionals involved with the family.

The challenge of unifying parents requires effective communication among professionals working with the family system. Sullivan (2019) has highlighted the importance of the use of collaborative multidisciplinary teams when working with high conflict families. In light of the recent uptick in adolescent mental health concerns, there has arguably never been a more important time for a cross-disciplinary approach to working with divorcing families. Collaborating with other professionals working with the family serves several functions, including gathering additional information, understanding others' perspectives on the family (which may shift our own), and working collaboratively towards the shared goal of maintaining family stability. In this way, a collaborative team approach promotes a more stable environment for the children involved, which is crucial in situations involving teen mental health crises.

PROMOTING FAMILY CONNECTEDNESS

If we listen to the "voices from the field" and professional perspectives that we have gathered, there is an urgent call across disciplines to place the needs of adolescents in a more central role in our work. That is, we need to raise the bar on the "best interests" standard for adolescents in order to protect their mental health and ensure that family involvement in the legal system quells rather than exacerbates their struggles.

This goal is best accomplished by assisting families in maintaining cohesiveness and stability through the process of separation, divorce, and litigation. This is true not only for family law professionals trained as mental health providers, but for all professionals working with families in transition. Children and adolescents in litigating families are in a uniquely vulnerable position, and our collective response as professionals informs their experience of the family's separation and divorce. When all professionals are functioning to serve the family by promoting family cohesiveness and stability, we can move towards achieving the goal of protecting child and adolescent mental health.

Support for this position is evident in recent research on protective factors for adolescent physical and mental health. Researchers have found that family connectedness plays a key role in long-term well-being for teens. Steiner et al. (2019) gathered longitudinal data over a 14 year period from high school into young adulthood from over 15,000 participants, and found that family connectedness had "long lasting protective effects across multiple health outcomes related to mental health, violence, sexual behavior, and substance use" (p. 7). Adolescent protective factors "buffer the negative effects of risk factors," and family connectedness was defined as a key buffer, connoting "a sense of caring, support, and belonging to family" (p. 2). In Steiner's comprehensive study, family connectedness was found to have "protective effects for emotional distress, all violence indicators, including intimate partner violence, multiple sex partners, sexually transmitted infection (STI) diagnosis, and [two] substance use indicators" (p. 7). In effect, the researchers found that family connectedness, coupled with school connectedness, were impactful protective factors for adolescents across multiple health-related domains and over the course of their adolescence into young adulthood.

These findings have profound relevance to the field of family law, as "family connectedness" is, in effect, what we are primarily struggling to assist families in developing and maintaining. It is widely understood that maintaining a sense of family stability through separation and divorce is in the best interests of children and their parents. A caveat to this general adherence is in situations of family violence or other mental health and substance abuse issues in which distance is needed to protect family members who have suffered as a result of another family member's behavior. Even when connectedness seems preferable for parents and children, family stability and connectedness are at great risk during separation and divorce; while many families restabilize, others continue to struggle significantly in ways that reinforce or negatively impact the mental health of the children involved. This is especially true among high conflict families, as well as those struggling with parent–child contact problems. In both instances, the children are placed at the center of the conflict and controversy, and the family system becomes the battleground

upon which the dysfunctional coparenting dynamic plays out. In many such situations, the sense of family connectedness is essentially broken, and adolescents struggle to maintain a sense of connectedness to one parent, or the other, although some may find stability through distance from both parents, focusing instead on school connectedness (Steiner et al., 2019) or connectedness to other organizations or institutions. A family that has "come apart" is infertile ground for adolescents struggling with mental or chronic health conditions. With the current rates of mental illness and suicidality reported by teens, discussed in most of the pieces in this Special Section, we must ask ourselves how our current practices and procedures are meeting the needs of this population at-risk for negative long term sequelae.

This raises several questions for family law professionals. What does it mean to strive to maintain family connectedness in a family that is, by definition, trying to disconnect through divorce and separation? How can we help children maintain that sense of family connectedness in spite of their change of living circumstances, living arrangements, schedules, and even the emotional and economic stability of the parents upon whom they depend? What is our role as family law professionals in fostering that stability as we serve our various roles as attorneys, judges, custody evaluators, parenting coordinators, therapists, and mediators? Most importantly, would a focus on maintenance of family connectedness potentially serve a preventive or protective function and result in a reduction of child and adolescent mental health crises in high conflict family law cases?

Consider the impact of placing family connectedness at the center of our work. Rather than attempting to figure out who is the better parent, or how much time each parent should have with the older child/adolescent, we would focus on helping the family reformulate in a way that maintained the greatest sense of stability for the children and adolescents involved. In this way, we might avoid O'Brien's description of the "red herring" of mental health in adolescents, recognizing that it is truly a family systems problem, and thus any solution must be approached using this perspective. Otherwise, we are likely to miss the forest for the trees, focusing on the struggles of individual adolescents rather than recognizing that their mental health crises are part of a larger systemic problem related to how families divorce within the current systems we use.

THE WAY FORWARD

Achieving the goal of maintaining family stability through separation and divorce can be Sisyphean, especially in a system that can be adversarial and divisive. It begins with a willingness to focus on conflict resolution as a primary goal—a true "best interests" approach—for all professionals involved. This will require the engagement of legal and mental health professionals through the use of collaborative multidisciplinary teams, and listening carefully to those working with adolescents to understand each youth's unique vulnerabilities and needs.

Several of the authors in this special section have noted that such a paradigm shift requires a willingness to reconsider established ways of operating. **Freed** noted a need for increased sensitivity to adolescents' role in court proceedings, given the increase in mental health concerns. She notes that when, and how to involve them, and how to best intercede on their behalf, takes on new meaning when working with an adolescent in crisis. **Shear's** paper examines how the "old ways" aren't always fitting the new paradigms, resulting in a system that often fails adolescents in crisis. She points out that "family law has not normalized the need to adapt parenting plans for the teen years," and makes suggestions for how this might best be rectified. She also highlights the need for courts and related professionals to respond to teen mental health concerns in a timely fashion, in order to avoid crises. **McNamara** shares how the state of Colorado has responded to the increase in teen suicides by allowing teens to access mental health treatment without parental consent. Authors **Pasternak and Montgomery** and **O'Brien** offer examples of new types of programs for high conflict parents that are designed to fill current gaps in efficacious interventions. These are all important examples of the ways in which this mental health crisis leads us to envision new ways of conducting our work.

It is a unifying theme that such a paradigm shift will involve structural changes to a system that is currently designed to make one-time family-related decisions and "move on" to the next case. Courts need to order periodic follow-up status hearings for families with a child in crisis, to ensure that needed services are in place and effectively address the adolescent's emergent mental health needs. This may include moving towards an increased willingness to alter parenting plans fluidly to meet the needs of adolescents in crisis. While this may initially seem burdensome to courts, it will hopefully reduce future litigation and serve as a protective factor for the youth involved. It may offer opportunities to bring family court and mental health courts together, or to create such entities where they do not now exist.

Of course, some family systems risk becoming more destabilized from parenting plan changes, so such actions will require careful forethought and a working relationship between parents and professionals to discourage alignment and/or estrangement between the children and one parent over the other. Experienced forensic mental health professionals who assess and work with families in conflict may be best suited to advise courts in such matters, to assist in setting up supportive structures to help families manage through periods of transition. Care must be taken, however, that professionals do not mandate or encourage numerous professionals who would not all be needed if careful interdisciplinary collaboration was instituted among wealthier families, or mandate services that are not economically feasible for families with fewer economic resources.

The requirement for parents to collaborate effectively and shield the child from conflict must also be placed front and center, and parents unable to manage their conflict effectively should be required to participate in interventions to assist them with this goal. In addition to conflict resolution, parents also need to focus on developing the positive coping attitudes, skills, and strategies necessary to cultivate a sense of family connectedness for their children. To accomplish this, courts may need to play a more active role in assuring that teens in crisis are obtaining not only the mental health services they need, but also the family stability important to their ability to thrive.

This points to the broader issue of family law professionals and courts needing to recognize and respond to the developmental needs of teens. We tend to focus on younger children in hopes that by adolescence, kids will be "on their own" and able to thrive without much concern. This could not be further from the truth. Adolescence is a time of great paradox. At this stage of development, teens are striving for independence, yet requiring a great degree of parental oversight due to increased exploration and risk-taking behavior. Raising adolescents is a balancing act between maintaining consistent guidelines and boundaries (to keep them safe) while also allowing for age-appropriate exploration and freedoms (to allow them to grow). No longer existing in the paradigm of "Mom's time and Dad's time" as they once did, they are beginning to manage their own lives to a greater degree, and may need more freedom and flexibility to do so. Some teens will demand such freedoms, while others do not dare to rock the boat of family tensions. While such flexibility may create problems when there are parent–child contact problems (necessitating adherence to a more rigid schedule), teens in homes with more effective coparenting teams may have different time-sharing requirements than their younger siblings; this is developmentally normative and appropriate. While parents are the ultimate decision-makers, teens may need to have more "say" in such matters, thereby moving the family away from a "Mom versus Dad" dynamic, towards a more child-focused paradigm. Helping parents support this developmental stage, rather than polarizing in response to it, is the work we face as professionals.

Providing guidance in accord with child development and mental health needs requires family law professionals to receive education in our latest research and interventions. The field of child development is changing rapidly, incorporating findings from brain research and neurobiology, as well as cultural factors influencing gender identity, sexuality, racial and ethnic development, and social media impacts on all of the aforementioned. In family law cases with an adolescent in crisis, the involvement of mental health knowledge is of utmost importance and can help shift the family's and the court's focus to the needs of the child. When involving mental health professionals, it is crucial to define their roles such that they are not simply coopted into the divorce system, but instead, are allowed to participate in a neutral therapeutic and/or advisory role. In this way, they can assist legal professionals in shifting from a focus on family conflict to ways that functional parenting and coparenting can promote family stability, thereby assisting in stabilizing the adolescent's environment.

In summary, as a result of this special section, we argue for the following system level changes.

Through increased awareness of the adolescent mental health crisis, we can gain a newfound recognition that children and adolescents in divorcing and litigating families constitute a fragile population. This recognition may lead us to approach them with a greater degree of sensitivity, and even humility, in our work. By striving to better understand their needs, and allowing those needs to drive our work rather than focusing primarily on the parents and the complexity of their conflict, we might best promote the sense of family connectedness needed to protect children at this most important and pivotal developmental stage.

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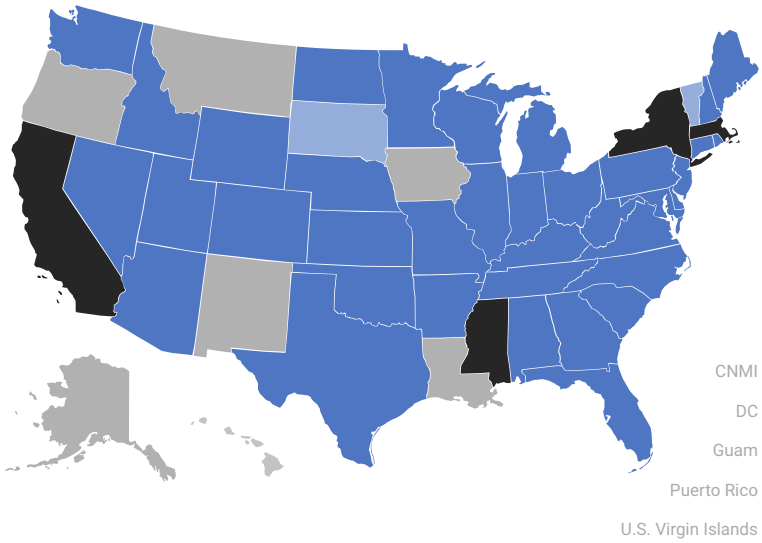

Map Key

- PSYPACT Participating State
- PSYPACT Legislation introduced
- Enacted PSYPACT Legislation - practice under PSYPACT not permitted
- Non- PSYPACT State/ no active Legislation

PSYPACT® PARTICIPATING STATES (41 ENACTED, 39 EFFECTIVE)

Alabama - AL SB 102 (Enacted 3/18/2021; Effective 6/1/2021)
Arizona - AZ HB 2503 (Enacted on 5/17/2016; Effective 7/1/2020)
Arkansas - AR HB 1760 (Enacted 4/25/2021; Effective (11/18/2021)
Colorado - CO HB 1017 (Enacted 4/12/2018; Effective 7/1/2020)
Commonwealth of the Northern Mariana Islands - CNMI HB 22-80 (Enacted and Effective 10/24/2022)
Connecticut -CT S 2(Enacted 5/24/2022; Effective 10/1/2022)
Delaware - DE HB 172 (Enacted 6/27/2019; Effective 7/1/2020)
District of Columbia - DC B 145 (Enacted and Effective 4/2/2021)
Florida -FL H 33(Enacted 5/25/2023; Effective 7/1/2023)
Georgia - GA HB 26 (Enacted 4/23/2019; Effective 7/1/2020)
Idaho - ID S 1305 (Enacted 3/23/2022; Effective 7/1/2022)
Illinois - IL HB 1853 (Enacted 8/22/2018, Effective 7/1/2020)
Indiana -IN S 365(Enacted 3/10/2022; Effective 7/1/2022)
Kansas - KS SB 170 (Enacted 5/17/2021; Effective 1/1/2022)
Kentucky - KY HB 38 (Enacted 3/18/2021; Effective 6/28/2021)
Maine - ME HB 631 (Enacted 6/22/2021; Effective 10/18/2021)
Maryland - MD HB 970 (Enacted and Effective 5/18/2021)
Michigan -MI H 5489(Enacted 12/22/2022; Effective 3/29/2023)
Minnesota - MN SB 193 (Enacted 5/25/2021; Effective 5/26/2021)
Missouri - MO HB 1719/MO SB 660 (Enacted 6/1/2018; Effective 7/1/2020)
Nebraska - NE L 1034 (Enacted 4/23/2018; Effective 7/1/2020)
Nevada - NV AB 429 (Enacted on 5/26/2017; Effective 7/1/2020)
New Hampshire- NH SB 232 (Enacted 7/10/2019; Effective 7/1/2020)
New Jersey -NJ A 4205(Enacted 9/24/2021; Effective 11/23/2021)

North Carolina - NC 361 (Enacted 7/1/2020; Effective 3/1/2021)
North Dakota - ND S 2205 (Enacted 4/13/2023; Effective 8/1/2023)
Ohio -OH S 2 (Enacted 4/27/2021; Effective 7/26/2021)
Oklahoma - OK HB 1057 (Enacted 4/29/2019; Effective 7/1/2020)
Pennsylvania- PA SB 67(Enacted 5/8/2020; Effective 7/8/2020)
Rhode Island -RI H 7501(Enacted 6/21/2022; Effective7/1/2023)
South Carolina -SC H 3204(Enacted 5/16/2023; Effective7/17/2023)
Tennessee -TN S 161 (Enacted and Effective 5/11/2021)
Texas - TX HB 1501 (Enacted 6/10/2019; Effective 7/1/2020)
Utah - UT SB 106 (Enacted on 3/17/2017; Effective 7/1/2020)
Virginia- VA SB 760(Enacted 4/11/2020; Effective 1/1/2021)
Washington -WA H 1286(Enacted 3/4/2022; Effective 6/9/2022)
West Virginia - WV SB 668 (Enacted 4/21/2021; Effective 11/18/2021)
Wisconsin -WI A 537 (Enacted 2/4/2022; Effective 2/6/2022)
Wyoming - WY S 26 (Enacted 2/15/2023; Effective 2/15/2023)

ENACTED, NOT YET EFFECTIVE

Vermont - VT H 282 (Enacted 6/1/2023; Effective 7/1/2024)
South Dakota - SD H 1017 (Enacted 2/13/24: Effective 7/1/2024)

ENACTED, UNDER FURTHER REVIEW

(* indicates PSYPACT legislation has been enacted in a state but has not been formally adopted by the PSYPACT Commission. PSYPACT authorizations are not yet valid in this state.)
N/A

ACTIVE PSYPACT LEGISLATION

*(*Please note the following states have introduced PSYPACT legislation but have not yet enacted PSYPACT and therefore are not considered PSYPACT participating states.)*

Introduced in 2023:

Massachusetts -MA S1980 and MA H2986

New York -NY S6883, NYA07947 and NYA9406

Introduced in 2024:

California -AB-2051

Mississippi -SB 2157

PREFILED LEGISLATION

(*Please note the following states have pre-filed legislation to be heard during the upcoming legislative session.)*

N/A

Non- PSYPACT States/Jurisdiction

*(*Please note the following states/jurisdiction have not enacted PSYPACT legislation nor do they have active PSYPACT legislation)*

Alaska
Guam
Iowa
Hawaii
Louisiana
Montana
New Mexico
Oregon
Puerto Rico
U.S. Virgin Islands

PSYPACT LEGISLATIVE UPDATE

What happens after a state enacts PSYPACT? Click **HERE** to learn more.

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Substance Use and Parenting

Best Practices for Family Court Practitioners

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

ASSOCIATION OF FAMILY AND CONCILIATION COURTS
Massachusetts AFCC

June 2021

TABLE OF CONTENTS

Acknowledgements

This guidebook is available without charge due to the limited resources that exist on this topic and urgent need for evidence-based information to support affected children and families. The editor and contributors agreed at the outset of this project that cost should not be a barrier for information. It is our hope that this publication is shared widely.

There are many people who helped to bring this book to fruition. I would like to start off by giving a special thank you to Jordana Douglas for the countless hours she spent reading and providing feedback on the numerous drafts of the book and for her thoughtful comments throughout the writing and editing process. She was integral to this project. Great things are ahead for you, Jordana – the sky is the limit. A special thank you to Donna Feinberg and Patricia Brady, who invited me to work on this project. Both viewed expanding evidence-based knowledge about addiction as critically important. Many thanks to those who took time out of their busy lives to read full drafts of the book and provided thoughtful, helpful feedback: Judge Beth Crawford, Judge Thomas Barbar, Judge Christina Harms, Jennifer Clapp, Payal Ravani, Abigail Judge, and Tony Pelusi.

One aspect of the book that is particularly special is that it was a true interdisciplinary endeavor. Each chapter in the book was reviewed by a mental health professional and an attorney. Thank you to the many chapter editors: Lisa Gallagher, Mira Levitt, Alicia Doherty, Stephen Burns, Kelly Flynn, Graham Garwood, Kathleen Michaud, Joanne Romanow, and Harry Somers.

Lastly, my sincere gratitude to the people I have worked with over the years with substance use disorders. I have learned from each of you and this book would not exist without you. Thank you.

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

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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

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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

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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

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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

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"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

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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

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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

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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

_____
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.

June 2021


ASSOCIATION OF FAMILY AND CONCILIATION COURTS
Massachusetts
AFCC

THEIMANN
ADVISORY
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University of North Carolina at Chapel Hill

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June 2009

FAQ on Services to Minors of Divorced Parents

Introduction

Theimann Advisories are periodic commentaries on the ethical, legal, and clinical implications of complex service dilemmas. They are issued with the support of the Smith P. Theimann, Jr. Distinguished Professorship in Ethics and Professional Practice and are distributed to alumni, students, and field instructors affiliated with the UNC Chapel Hill School of Social Work, as well as to the broader community of service providers.

Advisories use laws, ethics, and professional standards to craft recommendations in response to specific practice questions. They are intended to provide general guidelines for practice, but are not a substitute for legal advice or professional consultation and supervision on specific case matters. This Advisory utilizes North Carolina statutes in examining the issues presented. As such, some advice may not translate to other jurisdictions. Changes in laws, regulations and practice guidelines that occur after the advisory is issued may also affect the relevance of the recommendations.

This Advisory addresses the challenges presented in providing mental health or counseling services to minor clients whose parents are divorced or separated. It is intended to apply to the array of helping professionals, including social workers, counselors, and psychologists in a variety of child and adolescent service settings. Any meaningful distinctions among settings or types of professionals will be noted in the Advisory.

Understanding Custody

All states have statutes addressing custody of minor children. Few, however, define the terms used in discussing this issue. North Carolina is no different in this regard. The common understanding of "custody of a minor" refers to all the obligations and rights associated with the care, protection and control over the minor child.

The law uses the term "legal custody" to refer to the rights and obligations associated with making significant decisions affecting the child's life. These typically relate to health, schooling, religious instruction and other issues with long-term implications for the child. If one parent has the right to make all major decisions for the child that parent is commonly understood to have sole legal custody. If both parents share the right to make major decisions, or if certain decisions are divided between them, then it is assumed both parents have joint legal custody. The parent(s) with legal custody has the right to make these decisions even if financial support comes from somewhere else (Lee's North Carolina Family Law, §13.2b).

"Physical custody" refers to the obligations and rights of the person with whom the child resides. The parent with physical custody has the right to supervise the child, however decision making is limited to matters associated with the child's routine needs. Decisions such as where the child will attend school or what significant medical treatment the child might undergo typically have long-term consequences and therefore may only be made by the parent with legal custody. If the minor child resides with only one parent for significant periods of time then that parent is referred to as having primary physical custody or sole physical custody (Lee's North Carolina Family Law, §13.2c).

The standard used by the courts for determining custody of the minor child during divorce and separation proceedings is "the best interest of the child" (Lee's North Carolina Family Law, §50-13.2). "In North Carolina and in every state, a court may modify its order on the custody of a minor upon a change of circumstances affecting the welfare of the child" (Lee's North Carolina Family Law, §13.98a pg. 13-177). Parents are able to modify a court order regarding custody. To do so, courts require that there has been a substantial change of circumstances that affects the minor child and that modification is in the best interest of the child (Lee's North Carolina Family Law, §13.99). Thus, parents cannot seek modifications for trivial matters, but might so do if, for example, one parent was required to pay for medical expenses but then lost his/her job, or if the custodial parent became ill and was unable to fulfill that role as expected.

Since statutory law in North Carolina is silent on terms related to custody, this often contributes to problems when courts, lawyers, and custody orders fail to explain the agreements made between the parents. It is good practice that rights and responsibilities of each parent are clearly delineated in custody orders and that terms, such as joint custody, are fully explained. In fashioning a custody order, the court may also include a mechanism for resolving disagreements between parents with joint legal custody. In some jurisdictions, an "allocated parenting" agreement may be drafted to specify the rights and responsibilities between two competent but conflict-prone parents. These documents specify responsibility for significant events (visitation for holidays, payment of medical or dental expenses) as well as benign, but common, areas of dispute (payment for school clothes, field trips, summer camp, sports teams). Such "parallel parenting" arrangements anticipate disputes and attempt to address them proactively, removing children, therapists, health care providers, and others from conflicts between former spouses.

Frequently Asked Questions

1. If a parent brings a minor in for counseling, must the clinician/agency inquire about the presence of another parent and that person's consent for treatment? Does this change if payment/insurance is in the name of another adult?

Under North Carolina Law (GS 32A-30) the consent of one custodial parent would suffice, however practice advice suggests that the consent of both parents should be sought at the outset of (or before) treatment. Even though a non-custodial parent's consent is legally immaterial (DeKraai & Sales, 1991; Lawrence & Kurpius, 2000), it may still be ethically and clinically advisable to seek that person's assent (agreement) to treatment (Koocher, 2007).

Seeking consent of both parents serves a number of functions. It preemptively identifies disagreements between the parents about the nature of the child's difficulties and need for treatment. This information may prove relevant for case assessment and treatment planning. The transparency in involving both parents fulfills the ethical principles of veracity and fidelity (truthfulness and trustworthiness) and reduces the likelihood that the child or therapist will be triangulated between the parents.

Contacts with estranged or angry ex-spouses may be uncomfortable for all involved (and may be resisted by the parent presenting for service). Yet as Koocher suggests, "A parent who truly seeks to serve only the best interests of the child will not object to allowing contact with the other parent or to providing necessary documentation" to facilitate contact (2007, p. 12). Alternatively, the clinician may recommend that the presenting, custodial parent converse with the other parent about the decision to seek treatment in lieu of the clinician pursuing contact and securing permission.

Neither scenario is easy: work with minors of divorced or separated parents clearly lies as much in the field of family therapy as it does in specialty of child and adolescent treatment. Obtaining the consent of both parents involves navigating emotionally-charged and history-laden territory. Clinical resources can provide guidance about the dynamic issues following

marital dissolution and reintegration and the steps for helping parents come to terms with these challenges for the benefit of their children (Blow & Daniel, 2002; Visher & Visher, 1989).

Should the clinician decide to render treatment based solely upon one custodial parent's permission, he or she should discuss the possible repercussions of this stance with the parent (and the minor client, if age-appropriate). For example, if the parent with shared custody finds out about the treatment and objects to it, what steps must be taken? What will the agency disclose if the other parent seeks information about the care of the child, after discovering treatment absent his or her consent? These scenarios are addressed below, but their likelihood of occurring can be diminished if mutual consent is sought up front.

In any of these cases, the clinician should be certain to document the conversation and resulting decisions in the client's case record. Sound ethical decision making would also suggest that the worker discuss it with a supervisor, consultant, or knowledgeable colleague and document those findings as well (Strom-Gottfried, 2007)

A parent's obligation to pay a dependent's medical expenses is established as part of the divorce proceedings and is typically recorded in an order or agreement. The responsibility for payment is separate from custody and the capacity to give consent. Under an agreement of support, the custodial parent's authorization for service is valid by law. GS 50-13.11 outlines the procedures for the provision of health care and health insurance to minors. Either the court will assign the responsibility to one of the parents, or the parents enter into an agreement for medical support. According to sub-chapter (d), "When a court order or agreement for health insurance is in effect, the signature of either party shall be valid authorization to the insurer to process an insurance claim on behalf of a minor child." (see GS 50-13.11 below)

Although a non-custodial parent's consent for service is irrelevant, even if he or she is required to pay for the service, the clinician should still determine that person's role at the outset of treatment. As suggested above, informing this individual of the services and soliciting this person's assent for the treatment seems both ethically fair and clinically sound.

2. What obligation does the agency have to secure documentation that verifies custody status? How frequently should the agency request documentation? What type of documentation is sufficient?

Prudent practice suggests that the agency seek a copy of all materials related to the child's legal status. In cases of divorce, this would include obtaining a copy of the divorce decree (Carmichael, 2006) or "order of custody" and including it in the patient's record. Because circumstances can change (remarriage, job loss, relocation, etc) and parents can seek to alter an order, agencies should have a recommended schedule by which copies of orders are routinely sought (every six months, for example). In addition, if the clinician is aware of changes in family circumstances, he or she should seek copies of new orders outside that schedule as warranted.

3. How is informed consent executed with the other parent?

Ideally, the clinician would meet with the parents in person, individually or jointly to discuss the purpose, risks and costs of services, and available alternatives. The clinician should also describe the parents' rights to withhold or withdraw consent and any consequences of doing so (for example, implications for the child's condition, reports back to referring agencies, etc.). This information should be rendered in clear and understandable language, and reiterated as necessary throughout the treatment process. In addition to securing verbal consent, a formal, standardized informed consent document should be signed by both parents (Carmichael, 2006; DeKraai & Sales, 1991; Lawrence & Kurpius, 2000).

Typical informed consent conversations include discussions about the limits of confidentiality (suspected abuse, danger to self or other) and the clinician's policies on sharing content from counseling sessions with the client's parents. In cases involving divorced or estranged parents informed consent should also address the clinician's stance on sharing information with the other custodial parent. The obligation to share information with another custodial parent is addressed elsewhere in this Advisory.

In regard to non-custodial parents, the clinician's obligations are less clear. Some jurisdictions or divorce decrees might specify that parent's right to information. In other instances, the parent's access would be determined by the provider's preferences and the facts of the case. As such, the therapist may be willing to offer the non-custodial parent full, limited, or no access to case information. The important point is that the parameters should be made clear to all parties as part of the informed consent process and their agreement to that plan secured.

Because of distance and other factors, face-to-face meetings are sometimes impractical or impossible to arrange. The alternatives in this case include one-on-one phone conversations, a conference call with both parties, or letters to the parents. Verbal interactions clearly offer the opportunity for greater depth of explanation, and opportunities for questions and answers and for testing understanding of information shared. These correspondences can reference a written consent form which should be signed and returned to the agency.

4. What difference does it make if the parents have joint custody or one has sole custody?

If one parent has sole legal custody, then consent of that parent alone is sufficient for treatment. It is not necessary to seek consent from the other parent as that parent does not have legal decision making ability, however as discussed above, it may be clinically appropriate to seek the consent of both. If the parents have joint legal custody, then either parent may consent, but again, involving both adult figures may have therapeutic benefits and avoid disruptions later in the process.

5. What are the clinician's responsibilities in situations where both parents have legal custody but one parent consents to treatment and one refuses (for example, on the basis of cost or disputations about the need for or value of counseling)?

If the clinician agrees that treatment is unnecessary he or she can refuse to treat, explain and document the rationale, and suggest mechanisms by which the parents can more effectively resolve their differences about the care of their children. In the more common scenario, the clinician concurs with the need for treatment and thus is faced with a potential conflict of interest, in which advocating for treatment (ostensibly with him/her) is in his or her self interest and also allies the clinician with one parent and against another, when the cooperation of both is usually needed for the benefit of the child.

One way out of this entanglement is for the helping professional to address the parents' dispute as a singular goal for work. Should the parties be able come to an agreement to proceed with therapy for the child, that service would be provided by another professional or agency. Assisting an estranged couple to effectively communicate and create processes for addressing their children's needs is a worthwhile clinical objective in its own right, not simply an instrumental step to facilitate service to the child (Blow & Daniel, 2002; Visher & Visher, 1989).

Should the parents' impasse prove to be intractable, three further options exist. One would be for the parents to litigate the dispute so that a court stipulates parental rights as part of revised orders governing their custody arrangements and responsibilities. The disadvantages of this step are the cost, time involved and the perpetuation (and perhaps entrenchment) of existing conflict. In some cases, a court may intervene to force treatment against a custodial parent's wishes (Feigenbaum, 1991-1992). Courts may intervene over the objections of parents when the consequences of failing to provide treatment are severe and the treatment sought involves little risk to the child. (Lee's North Carolina Family Law, §50-15.29 f). Numerous court cases have upheld the court's authority to order medical treatment when a parent unreasonably withholds consent though these cases typically concern invasive medical procedures that substantially affect the child's health or safety, rather than less urgent matters of mental health or other forms of counseling. In processes such as this, a petition is filed for a judicial finding that the child is neglected or dependant and a guardian ad litem is appointed to represent the minor's interests "in any proceeding, formal or informal" (Feigenbaum, 1991-1992, p. 843). This helps assure that the child's needs are not subordinated to the parent's enmity for each other or their individual interests.

Options to adjudication include alternative dispute resolution (ADR) processes such as arbitration or mediation in which the parents would work with an individual trained to help the parties air their differences, hear the others' perspective, and reach a mutually agreeable conclusion. In some instances, arbitration is binding, and in those, the decision of the arbitrator, not the individuals, would take precedence. While ADR is less adversarial than adjudication of grievances, it can be time consuming, and must be carefully constructed so that the less powerful or vocal party is not disadvantaged in negotiations or compromise. In some high-conflict divorces, the involvement of a guardian ad litem (GAL) may be mandated by the court. In this event, the GAL would be an appropriate resource for arbitration or mediation of this and other areas of disagreement.

As a final option to parental disputes about minor's care, the case could be referred to child welfare authorities for determination of medical neglect. Chapter 7B of the NC General Statutes outlines the policies and procedures for adjudication of cases of juvenile abuse, neglect, and dependency. The code includes in the definition of a neglected juvenile any minor "who is not provided necessary medical care; or who is not provided necessary remedial care" (NC GS § 7B-101.

Definitions). Cases of neglect may also connote abuse if the responsible adult "creates or allows to be created serious emotional damage to the juvenile;" which is "evidenced by a juvenile's severe anxiety, depression, withdrawal, or aggressive behavior toward himself or others" (NC GS § 7B-101. Definitions). Cases of abuse may be pursued by law enforcement, and entail criminal proceedings.

It is wise to seek consultation from experts in child welfare and/or child protective service personnel prior to making a referral on the basis on medical neglect. While such referral may in some instances be clearly necessary for the worker to fulfill his or her role as a mandated reported, ambiguous or punitive referrals by professionals (or a disaffected parent) will likely escalate conflict and alienation rather than a resolution that is ultimately helpful to the child.

6. What if the parent presenting for service explicitly requests that the other parent not be contacted because of some compelling reason (a history of explosive anger, abuse, instability, or paranoia)?

There may indeed be situations in which it is impractical, unsafe, or unsound to involve a noncustodial parent in assenting to the child's treatment. If the reasons for excluding the other parent are formally documented (for example, incarceration or termination of parental rights) "the word of one parent should require corroboration (e.g. a confirmatory letter from a member of the bar or a copy of a court order)" (Koocher, 2007, p.12). If the concerns have not been formally established, the clinician should explore the basis for the presenting parent's apprehensions, any substantiation for the parent's claims, the nature and scope of the anticipated services, and the implications of serving the child without informing the other parent. The clinician should seek consultation about the implications of proceeding with treatment and review those with the presenting parent. For example, what are the likely repercussions (for the child client and others) if the noncustodial parent learns of the treatment and demands access to records or other information about the care provided? If the clinician ultimately determines that consulting with both parents is contraindicated (or that one parent should be denied access to records) the clinician should document the steps taken to reach this decision and the information supporting it.

7. What responsibility does the agency have to share information with the other parent if he/she seeks information about the status of that child's care? Does this obligation differ if the parent requesting information is non-custodial?

According to Corbet (2006) divorced parents have equal access to their child's record unless a court order specifies differently. GS 50-13.2 reads, "Absent an order of the court to the contrary, each parent shall have equal access to the records of the minor child involving the health, education, and welfare of the child." Therefore both parents have equal rights to the medical records upon request, barring any other scenarios that would preclude disclosure (i.e., when the disclosure serves the parent's interest and is not in the best interest of the child). It is important though, to differentiate the right of access from the right to give consent. While access to records may be available upon request, a parent without legal custody may not consent to significant medical/psychiatric treatment.

The NASW Code of Ethics (2008) stipulates that "social workers should provide clients with reasonable access to records concerning the clients. Social workers who are concerned that clients' access to their records could cause serious misunderstanding or harm to the client should provide assistance in interpreting the records and consultation with the client regarding the records. Social workers should limit clients' access to their records, or portions of their records, only in exceptional circumstances when there is compelling evidence that such access would cause serious harm to the client. Both clients' requests and the rationale for withholding some or all of the record should be documented in clients' files"(1.08).

While the Code does not differentiate minor's records from those of adult clients, the guidance provided about access, limits, and documentation of related decisions is germane to minors' records and parental access.

8. If a grandparent (or other non-parent relative) brings a minor in for counseling, must the clinician/agency inquire about the parent? What if the parent is incarcerated, resides in another state, is hospitalized or otherwise unavailable?

GS 32A Article 4 (see Appendix below) outlines procedures for "delegating the decisions to health care for the parent's minor child when the parent is unavailable for a period of time by reason of travel or otherwise." In the following section we discuss the conditions under which services should be rendered without a parent's consent. In instances other than those described below, it seems unwise to serve a minor on an extended basis without parental permission, even though the minor may be presented for service by a relative or other responsible adult.

This is clearly an ethical dilemma, in that the duty to serve, especially in a compelling case of a distraught or needy minor, is in conflict with a parent's right to approve or disapprove of non-emergency services for his or her child. A clinician or agency may bridge this divide by providing circumscribed and time-limited assistance in the case, for example, meeting with the minor and presenting adult in order to assess the situation, rule out emergent circumstances, and advise the adult on steps to secure custody. Assisting the adult may include providing a list of attorneys who could help with custody proceedings, consulting with child welfare authorities about their jurisdiction or assistance in the case, and exploring with the adult the assistance and documentation needed to carry out other responsibilities for the minor. If the provider believes that more extensive involvement is warranted without parental permission, he or she should seek legal, ethical and clinical consultation about the impetus for this decision and other available options. Possible consequences for agencies or individuals who provide non urgent services without parental consent include complaints to licensure or regulatory authorities and civil actions.

9. In what situations can treatment be given to minors without parental consent?

Jill Moore (2005) notes five situations mentioned in the General Statutes which constitute exceptions to the parental consent mandate. 1) Parent authorizes another adult to give consent [GS 32A-Article 4]; 2) Emergencies and other circumstances [GS 90-21.1]; 3) Immunizations: A physician or local health department may immunize a minor who is presented for immunization by an adult who signs a statement that he or she has been authorized by the parent, guardian, or parent in loco parentis, to obtain the immunization for the minor [GS 130A-153(d)]; 4) Emancipated minors [GS 90-21.5]; 5) Minor's consent law [GS 90-21.5] allows physicians to accept unemancipated minors' consent for treatment for the prevention, diagnosis, or treatment of venereal and other reportable communicable diseases, pregnancy, abuse of controlled substances or alcohol, or emotional disturbance. Exceptions to the rule include: sterilization, abortion, or admission to a 24-hour mental health or substance abuse facility (except in an emergency). Note: a health care provider must not accept a person's consent to treatment without evidence of decisional capacity to do so. Thus the consent must be voluntary, knowing and competent (Sales, DeKraai, Hall, & Duval, 2008).

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References and Resources

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Appendices

Emancipation in NC - (Corbet, 2006)

- Emancipation by petition (over age 16), or by marriage (as young as 14). Parental consent is required for 14-15 year-olds to marry.

North Carolina General Statutes
Chapter 90 (Medicine and Allied Occupations)
DeVito's note: There's language in this chapter that addresses some of the consent questions; however, the articles seem to be aimed (and limited?) to the practice of medicine. I'm not certain that either of these articles apply to counselors.

§ 90-21.1. When physician may treat minor without consent of parent, guardian or person in loco parentis.

It shall be lawful for any physician licensed to practice medicine in North Carolina to render treatment to any minor without first obtaining the consent and approval of **either** the father or mother of said child, or any person acting as guardian, or any person standing in loco parentis to said child where:

(1) The parent or parents, the guardian, or a person standing in loco parentis to said child cannot be located or contacted with reasonable diligence during the time within which said minor needs to receive the treatment herein authorized, or

(2) Where the identity of the child is unknown, or where the necessity for immediate treatment is so apparent that any effort to secure approval would delay the treatment so long as to endanger the life of said minor, or

(3) Where an effort to contact a parent, guardian, or person standing in loco parentis would result in a delay that would seriously worsen the physical condition of said minor, or

(4) Where the parents refuse to consent to a procedure, and the necessity for immediate treatment is so apparent that the delay required to obtain a court order would endanger the life or seriously worsen the physical condition of the child. No treatment shall be administered to a child over the parent's objection as herein authorized unless the physician shall first obtain the opinion of another physician licensed to practice medicine in the State of North Carolina that such procedure is necessary to prevent immediate harm to the child.

Provided, however, that the refusal of a physician to use, perform or render treatment to a minor without the consent of the minor's parent, guardian, or person standing in the position of loco parentis, in accordance with this Article, shall not constitute grounds for a civil action or criminal proceedings against such physician. (1965, c. 810, s. 1; 1977, c. 625, s. 1.)

§ 90-21.5. Minor's consent sufficient for certain medical health services.

(a) Any minor may give effective consent to a physician licensed to practice medicine in North Carolina for medical health services for the prevention, diagnosis and treatment of (i) venereal disease and other diseases reportable under G.S. 130A-135, (ii) pregnancy, (iii) abuse of controlled substances or alcohol, and (iv) emotional disturbance. This section does not authorize the inducing of an abortion, performance of a sterilization operation, or admission to a 24-hour facility licensed under Article 2 of Chapter 122C of the General Statutes except as provided in G.S. 122C-222. This section does not

prohibit the admission of a minor to a treatment facility upon his own written application in an emergency situation as authorized by G.S. 122C-222.

(b) Any minor who is emancipated may consent to any medical treatment, dental and health services for himself or for his child. (1971, c. 35; 1977, c. 582, s. 2; 1983, c. 302, s. 2; 1985, c. 589, s. 31; 1985 (Reg. Sess., 1986), c. 863, s. 4.)

Chapter 32A – Powers of Attorney

§ 32A-28. Purpose.

(a) The General Assembly recognizes as a matter of public policy the fundamental right of a parent to delegate decisions relating to health care for the parent's minor child where the parent is unavailable for a period of time by reason of travel or otherwise.

(b) The purpose of this Article is to establish a nonexclusive method for a parent to authorize in the parent's absence consent to health care for the parent's minor child. This Article is not intended to be in derogation of the common law or of Article 1A of Chapter 90 of the General Statutes. (1993, c. 150, s. 1.)

§ 32A-29. Definitions.

As used in this Article, unless the context clearly requires otherwise, the term:

(1) "Agent" means the person authorized pursuant to this Article to consent to and authorize health care for a minor child.

(2) "Authorization to consent to health care for minor" means a written instrument, signed by the custodial parent and acknowledged before a notary public, pursuant to which the custodial parent authorizes an agent to authorize and consent to health care for the minor child of the custodial parent, and which substantially meets the requirements of this Article.

(3) "Custodial parent" means a parent having sole or joint legal custody of that parent's minor child.

(4) **"Health care" means any care, treatment, service or procedure to maintain, diagnose, treat, or provide for a minor child's physical or mental or personal care and comfort, including life sustaining procedures and dental care.**

(5) "Life sustaining procedures" are those forms of care or treatment which only serve to artificially prolong life and may include mechanical ventilation, dialysis, antibiotics, artificial nutrition and hydration, and other forms of treatment which sustain, restore, or supplant vital bodily functions, but do not include care necessary to provide comfort or to alleviate pain.

(6) "Minor or minor child" means an individual who has not attained the age of 18 years and who has not been emancipated. (1993, c. 150.)

§ 32A-30. Who may make an authorization to consent to health care for minor.

Any custodial parent having understanding and capacity to make and communicate health care decisions who is 18 years of age or older or who is emancipated may make an authorization to consent to health care for the parent's minor child. (1993, c. 150, s. 1.)

§ 32A-34. Statutory form authorization to consent to health care for minor.

The use of the following form in the creation of any authorization to consent to health care for minor is lawful and, when used, it shall meet the requirements and be construed in accordance with the provisions of this Article.

"Authorization to Consent to Health Care for Minor."

I, _____, of _____ County, _____, am the custodial parent having legal custody of_____, a minor child, age_____, born_____, ____ . I authorize_____, an adult in whose care the minor child has been entrusted, and who resides at_____, to do any acts which may be necessary or proper to provide for the health care of the minor child, including, but not limited to, the power (i) to provide for such health care at any hospital or other institution, or the employing of any physician, dentist, nurse, or other person whose services may be needed for such health care, and (ii) to consent to and authorize any health care, including administration of anesthesia, X-ray examination, performance of operations, and other procedures by physicians, dentists, and other medical personnel except the withholding or withdrawal of life sustaining procedures.

[Optional: This consent shall be effective from the date of execution to and including_____,_____].

By signing here, I indicate that I have the understanding and capacity to communicate health care decisions and that I am fully informed as to the contents of this document and understand the full import of this grant of powers to the agent named herein.

(SEAL)
Custodial Parent Date

STATE OF NORTH CAROLINA

COUNTY OF

On this _____ day of_____, ____, personally appeared before me the named_____, to me known and known to me to be the person described in and who executed the foregoing instrument and he (or she) acknowledges that he (or she) executed the same and being duly sworn by me, made oath that the statements in the foregoing instrument are true.

Notary Public

My Commission Expires:

(OFFICIAL SEAL). (1993, c. 150, s. 1; 1999-456, s. 59.)

§ 50-13.11. Orders and agreements regarding medical support and health insurance coverage for minor children.

(a) The court may order a parent of a minor child or other responsible party to provide medical support for the child, or the parties may enter into a written agreement regarding medical support for the child. An order or agreement for medical support for the child may require one or both parties to pay the medical, hospital, dental, or other health care related expenses.

(a1) The court shall order the parent of a minor child or other responsible party to maintain health insurance for the benefit of the child when health insurance is available at a reasonable cost. If health insurance is not presently available at a reasonable cost, the court shall order the parent of a minor child or other responsible party to maintain health insurance for the benefit of the child when health insurance becomes available at a reasonable cost. As used in this subsection, health insurance is

considered reasonable in cost if it is employment related or other group health insurance, regardless of service delivery mechanism. The court may require one or both parties to maintain dental insurance.
(b) The party ordered or under agreement to provide health insurance shall provide written notice of any change in the applicable insurance coverage to the other party.
(c) The employer or insurer of the party required to provide health, hospital, and dental insurance shall release to the other party, upon written request, any information on a minor child's insurance coverage that the employer or insurer may release to the party required to provide health, hospital, and dental insurance.
(d) When a court order or agreement for health insurance is in effect, the signature of either party shall be valid authorization to the insurer to process an insurance claim on behalf of a minor child.
(e) If the party who is required to provide health insurance fails to maintain the insurance coverage for the minor child, the party shall be liable for any health, hospital, or dental expenses incurred from the date of the court order or agreement that would have been covered by insurance if it had been in force.
(f) When a noncustodial parent ordered to provide health insurance changes employment and health insurance coverage is available through the new employer, the obligee shall notify the new employer of the noncustodial parent's obligation to provide health insurance for the child. Upon receipt of notice from the obligee, the new employer shall enroll the child in the employer's health insurance plan. (1989 (Reg. Sess., 1990), c. 1067, s. 1; 1991, c. 419, s. 2; c. 761, s. 42; 1997-433, s. 3.1; 1998-17, s. 1; 2003-288, s. 3.2.)

Specialty Guidelines for Forensic Psychology

American Psychological Association

In the past 50 years forensic psychological practice has expanded dramatically. The American Psychological Association (APA) has a division devoted to matters of law and psychology (APA Division 41, the American Psychology–Law Society), a number of scientific journals devoted to interactions between psychology and the law exist (e.g., *Law and Human Behavior; Psychology, Public Policy, and Law; Behavioral Sciences & the Law*), and a number of key texts have been published and undergone multiple revisions (e.g., Grisso, 1986, 2003; Melton, Petrila, Poythress, & Slobogin, 1987, 1997, 2007; Rogers, 1988, 1997, 2008). In addition, training in forensic psychology is available in predoctoral, internship, and postdoctoral settings, and APA recognized forensic psychology as a specialty in 2001, with subsequent recertification in 2008.

Because the practice of forensic psychology differs in important ways from more traditional practice areas (Monahan, 1980) the "Specialty Guidelines for Forensic Psychologists" were developed and published in 1991 (Committee on Ethical Guidelines for Forensic Psychologists, 1991). Because of continued developments in the field in the ensuing 20 years, forensic practitioners' ongoing need for guidance, and policy requirements of APA, the 1991 "Specialty Guidelines for Forensic Psychologists" were revised, with the intent of benefiting forensic practitioners and recipients of their services alike.

The goals of these Specialty Guidelines for Forensic Psychology ("the Guidelines") are to improve the quality of forensic psychological services; enhance the practice and facilitate the systematic development of forensic psychology; encourage a high level of quality in professional practice; and encourage forensic practitioners to acknowledge and respect the rights of those they serve. These Guidelines are intended for use by psychologists when engaged in the practice of forensic psychology as described below and may also provide guidance on professional conduct to the legal system and other organizations and professions.

For the purposes of these Guidelines, *forensic psychology* refers to professional practice by any psychologist working within any subdiscipline of psychology (e.g., clinical, developmental, social, cognitive) when applying the scientific, technical, or specialized knowledge of psychology to the law to assist in addressing legal, contractual, and administrative matters. Application of the Guidelines does not depend on the practitioner's typical areas of practice or expertise, but rather, on the service provided in the case at hand. These Guidelines apply in all matters in which psychologists provide expertise to judicial, administrative, and educational systems including, but not limited to, examining or treating persons in anticipation of or subsequent to legal, contractual, or administrative proceedings; offering expert opinion about psychological issues in the form of amicus briefs or testimony to judicial, legislative, or administrative bodies; acting in an adjudicative capacity; serving as a trial consultant or otherwise offering expertise to attorneys, the courts, or others; conducting research in connection with, or in the anticipation of, litigation; or involvement in educational activities of a forensic nature.

Psychological practice is not considered forensic solely because the conduct takes place in, or the product is presented in, a tribunal or other judicial, legislative, or administrative forum. For example, when a party (such as a civilly or criminally detained individual) or another individual (such as a child whose parents are involved in divorce proceedings) is ordered into treatment with a practitioner, that treatment is not necessarily the practice of forensic psychology. In addition, psychological testimony that is solely based on the provision of psychotherapy and does not include psycholegal opinions is not ordinarily considered forensic practice.

For the purposes of these Guidelines, *forensic practitioner* refers to a psychologist when engaged in the practice of forensic psychology as described above. Such professional conduct is considered forensic from the time the practitioner reasonably expects to, agrees to, or is legally mandated to provide expertise on an explicitly psycholegal issue.

The provision of forensic services may include a wide variety of psycholegal roles and functions. For example, as

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These Specialty Guidelines for Forensic Psychology were developed by the American Psychology–Law Society (Division 41 of the American Psychological Association [APA]) and the American Academy of Forensic Psychology. They were adopted by the APA Council of Representatives on August 3, 2011.

The previous version of the Guidelines ("Specialty Guidelines for Forensic Psychologists"; Committee on Ethical Guidelines for Forensic Psychologists, 1991) was approved by the American Psychology–Law Society (Division 41 of APA) and the American Academy of Forensic Psychology in 1991. The current revision, now called the "Specialty Guidelines for Forensic Psychology" (referred to as "the Guidelines" throughout this document), replaces the 1991 "Specialty Guidelines for Forensic Psychologists."

These guidelines are scheduled to expire August 3, 2021. After this date, users are encouraged to contact the American Psychological Association Practice Directorate to confirm that this document remains in effect.

Correspondence concerning these guidelines should be addressed to the Practice Directorate, American Psychological Association, 750 First Street, NE, Washington, DC 20002-4242.

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researchers, forensic practitioners may participate in the collection and dissemination of data that are relevant to various legal issues. As advisors, forensic practitioners may provide an attorney with an informed understanding of the role that psychology can play in the case at hand. As consultants, forensic practitioners may explain the practical implications of relevant research, examination findings, and the opinions of other psycholegal experts. As examiners, forensic practitioners may assess an individual's functioning and report findings and opinions to the attorney, a legal tribunal, an employer, an insurer, or others (APA, 2010b, 2011a). As treatment providers, forensic practitioners may provide therapeutic services tailored to the issues and context of a legal proceeding. As mediators or negotiators, forensic practitioners may serve in a third-party neutral role and assist parties in resolving disputes. As arbiters, special masters, or case managers with decision-making authority, forensic practitioners may serve parties, attorneys, and the courts (APA, 2011b).

These Guidelines are informed by APA's "Ethical Principles of Psychologists and Code of Conduct" (hereinafter referred to as the EPPCC; APA, 2010a). The term *guidelines* refers to statements that suggest or recommend specific professional behavior, endeavors, or conduct for psychologists. Guidelines differ from standards in that standards are mandatory and may be accompanied by an enforcement mechanism. Guidelines are aspirational in intent. They are intended to facilitate the continued systematic development of the profession and facilitate a high level of practice by psychologists. Guidelines are not intended to be mandatory or exhaustive and may not be applicable to every professional situation. They are not definitive, and they are not intended to take precedence over the judgment of psychologists.

As such, the Guidelines are advisory in areas in which the forensic practitioner has discretion to exercise professional judgment that is not prohibited or mandated by the EPPCC or applicable law, rules, or regulations. The Guidelines neither add obligations to nor eliminate obligations from the EPPCC but provide additional guidance for psychologists. The modifiers used in the Guidelines (e.g., *reasonably, appropriate, potentially*) are included in recognition of the need for professional judgment on the part of forensic practitioners; ensure applicability across the broad range of activities conducted by forensic practitioners; and reduce the likelihood of enacting an inflexible set of guidelines that might be inapplicable as forensic practice evolves. The use of these modifiers, and the recognition of the role of professional discretion and judgment, also reflects that forensic practitioners are likely to encounter facts and circumstances not anticipated by the Guidelines and they may have to act upon uncertain or incomplete evidence. The Guidelines may provide general or conceptual guidance in such circumstances. The Guidelines do not, however, exhaust the legal, professional, moral, and ethical considerations that inform forensic practitioners, for no complex activity can be completely defined by legal rules, codes of conduct, and aspirational guidelines.

The Guidelines are not intended to serve as a basis for disciplinary action or civil or criminal liability. The standard of care is established by a competent authority, not by the Guidelines. No ethical, licensure, or other administrative action or remedy, nor any other cause of action, should be taken *solely* on the basis of a forensic practitioner acting in a manner consistent or inconsistent with these Guidelines.

In cases in which a competent authority references the Guidelines when formulating standards, the authority should consider that the Guidelines attempt to identify a high level of quality in forensic practice. Competent practice is defined as the conduct of a reasonably prudent forensic practitioner engaged in similar activities in similar circumstances. Professional conduct evolves and may be viewed along a continuum of adequacy, and "minimally competent" and "best possible" are usually different points along that continuum.

The Guidelines are designed to be national in scope and are intended to be consistent with state and federal law. In cases in which a conflict between legal and professional obligations occurs, forensic practitioners make known their commitment to the EPPCC and the Guidelines and take steps to achieve an appropriate resolution consistent with the EPPCC and the Guidelines.

The format of the Guidelines is different from most other practice guidelines developed under the auspices of APA. This reflects the history of the Guidelines as well as the fact that the Guidelines are considerably broader in scope than any other APA-developed guidelines. Indeed, these are the only APA-approved guidelines that address a complete specialty practice area. Despite this difference in format, the Guidelines function as all other APA guideline documents.

This document replaces the 1991 "Specialty Guidelines for Forensic Psychologists," which were approved by the American Psychology–Law Society (Division 41 of APA) and the American Board of Forensic Psychology. The current revision has also been approved by the Council of Representatives of APA. Appendix A includes a discussion of the revision process, enactment, and current status of these Guidelines. Appendix B includes definitions and terminology as used for the purposes of these Guidelines.

1. Responsibilities

Guideline 1.01: Integrity

Forensic practitioners strive for accuracy, honesty, and truthfulness in the science, teaching, and practice of forensic psychology and they strive to resist partisan pressures to provide services in any ways that might tend to be misleading or inaccurate.

Guideline 1.02: Impartiality and Fairness

When offering expert opinion to be relied upon by a decision maker, providing forensic therapeutic services, or teaching or conducting research, forensic practitioners strive for accuracy, impartiality, fairness, and independence (EPPCC Standard 2.01). Forensic practitioners rec-

ognize the adversarial nature of the legal system and strive to treat all participants and weigh all data, opinions, and rival hypotheses impartially.

When conducting forensic examinations, forensic practitioners strive to be unbiased and impartial, and avoid partisan presentation of unrepresentative, incomplete, or inaccurate evidence that might mislead finders of fact. This guideline does not preclude forceful presentation of the data and reasoning upon which a conclusion or professional product is based.

When providing educational services, forensic practitioners seek to represent alternative perspectives, including data, studies, or evidence on both sides of the question, in an accurate, fair and professional manner, and strive to weigh and present all views, facts, or opinions impartially.

When conducting research, forensic practitioners seek to represent results in a fair and impartial manner. Forensic practitioners strive to utilize research designs and scientific methods that adequately and fairly test the questions at hand, and they attempt to resist partisan pressures to develop designs or report results in ways that might be misleading or unfairly bias the results of a test, study, or evaluation.

Guideline 1.03: Avoiding Conflicts of Interest

Forensic practitioners refrain from taking on a professional role when personal, scientific, professional, legal, financial, or other interests or relationships could reasonably be expected to impair their impartiality, competence, or effectiveness, or expose others with whom a professional relationship exists to harm (EPPCC Standard 3.06).

Forensic practitioners are encouraged to identify, make known, and address real or apparent conflicts of interest in an attempt to maintain the public confidence and trust, discharge professional obligations, and maintain responsibility, impartiality, and accountability (EPPCC Standard 3.06). Whenever possible, such conflicts are revealed to all parties as soon as they become known to the psychologist. Forensic practitioners consider whether a prudent and competent forensic practitioner engaged in similar circumstances would determine that the ability to make a proper decision is likely to become impaired under the immediate circumstances.

When a conflict of interest is determined to be manageable, continuing services are provided and documented in a way to manage the conflict, maintain accountability, and preserve the trust of relevant others (also see Guideline 4.02 below).

2. Competence

Guideline 2.01: Scope of Competence

When determining one's competence to provide services in a particular matter, forensic practitioners may consider a variety of factors including the relative complexity and specialized nature of the service, relevant training and experience, the preparation and study they are able to devote to the matter, and the opportunity for consultation with a professional of established competence in the subject matter in question. Even with regard to subjects in which they are expert, forensic practitioners may choose to consult with colleagues.

Guideline 2.02: Gaining and Maintaining Competence

Competence can be acquired through various combinations of education, training, supervised experience, consultation, study, and professional experience. Forensic practitioners planning to provide services, teach, or conduct research involving populations, areas, techniques, or technologies that are new to them are encouraged to undertake relevant education, training, supervised experience, consultation, or study.

Forensic practitioners make ongoing efforts to develop and maintain their competencies (EPPCC Standard 2.03). To maintain the requisite knowledge and skill, forensic practitioners keep abreast of developments in the fields of psychology and the law.

Guideline 2.03: Representing Competencies

Consistent with the EPPCC, forensic practitioners adequately and accurately inform all recipients of their services (e.g., attorneys, tribunals) about relevant aspects of the nature and extent of their experience, training, credentials, and qualifications, and how they were obtained (EPPCC Standard 5.01).

Guideline 2.04: Knowledge of the Legal System and the Legal Rights of Individuals

Forensic practitioners recognize the importance of obtaining a fundamental and reasonable level of knowledge and understanding of the legal and professional standards, laws, rules, and precedents that govern their participation in legal proceedings and that guide the impact of their services on service recipients (EPPCC Standard 2.01).

Forensic practitioners aspire to manage their professional conduct in a manner that does not threaten or impair the rights of affected individuals. They may consult with, and refer others to, legal counsel on matters of law. Although they do not provide formal legal advice or opinions, forensic practitioners may provide information about the legal process to others based on their knowledge and experience. They strive to distinguish this from legal opinions, however, and encourage consultation with attorneys as appropriate.

Guideline 2.05: Knowledge of the Scientific Foundation for Opinions and Testimony

Forensic practitioners seek to provide opinions and testimony that are sufficiently based upon adequate scientific foundation, and reliable and valid principles and methods that have been applied appropriately to the facts of the case.

When providing opinions and testimony that are based on novel or emerging principles and methods, forensic practitioners seek to make known the status and limitations of these principles and methods.

Guideline 2.06: Knowledge of the Scientific Foundation for Teaching and Research

Forensic practitioners engage in teaching and research activities in which they have adequate knowledge, experience, and education (EPPCC Standard 2.01), and they acknowledge relevant limitations and caveats inherent in procedures and conclusions (EPPCC Standard 5.01).

Guideline 2.07: Considering the Impact of Personal Beliefs and Experience

Forensic practitioners recognize that their own cultures, attitudes, values, beliefs, opinions, or biases may affect their ability to practice in a competent and impartial manner. When such factors may diminish their ability to practice in a competent and impartial manner, forensic practitioners may take steps to correct or limit such effects, decline participation in the matter, or limit their participation in a manner that is consistent with professional obligations.

Guideline 2.08: Appreciation of Individual and Group Differences

When scientific or professional knowledge in the discipline of psychology establishes that an understanding of factors associated with age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, socioeconomic status, or other relevant individual and cultural differences affects implementation or use of their services or research, forensic practitioners consider the boundaries of their expertise, make an appropriate referral if indicated, or gain the necessary training, experience, consultation, or supervision (EPPCC Standard 2.01; APA, 2003, 2004, 2011c, 2011d, 2011e).

Forensic practitioners strive to understand how factors associated with age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, socioeconomic status, or other relevant individual and cultural differences may affect and be related to the basis for people's contact and involvement with the legal system.

Forensic practitioners do not engage in unfair discrimination based on such factors or on any basis proscribed by law (EPPCC Standard 3.01). They strive to take steps to correct or limit the effects of such factors on their work, decline participation in the matter, or limit their participation in a manner that is consistent with professional obligations.

Guideline 2.09: Appropriate Use of Services and Products

Forensic practitioners are encouraged to make reasonable efforts to guard against misuse of their services and exercise professional discretion in addressing such misuses.

3. Diligence

Guideline 3.01: Provision of Services

Forensic practitioners are encouraged to seek explicit agreements that define the scope of, time-frame of, and compensation for their services. In the event that a client breaches the contract or acts in a way that would require the practitioner to violate ethical, legal or professional obligations, the forensic practitioner may terminate the relationship.

Forensic practitioners strive to act with reasonable diligence and promptness in providing agreed-upon and reasonably anticipated services. Forensic practitioners are not bound, however, to provide services not reasonably anticipated when retained, nor to provide every possible aspect or variation of service. Instead, forensic practitioners may exercise professional discretion in determining the extent and means by which services are provided and agreements are fulfilled.

Guideline 3.02: Responsiveness

Forensic practitioners seek to manage their workloads so that services can be provided thoroughly, competently, and promptly. They recognize that acting with reasonable promptness, however, does not require the forensic practitioner to acquiesce to service demands not reasonably anticipated at the time the service was requested, nor does it require the forensic practitioner to provide services if the client has not acted in a manner consistent with existing agreements, including payment of fees.

Guideline 3.03: Communication

Forensic practitioners strive to keep their clients reasonably informed about the status of their services, comply with their clients' reasonable requests for information, and consult with their clients about any substantial limitation on their conduct or performance that may arise when they reasonably believe that their clients expect a service that is not consistent with their professional obligations. Forensic practitioners attempt to keep their clients reasonably informed regarding new facts, opinions, or other potential evidence that may be relevant and applicable.

Guideline 3.04: Termination of Services

The forensic practitioner seeks to carry through to conclusion all matters undertaken for a client unless the forensic practitioner–client relationship is terminated. When a forensic practitioner's employment is limited to a specific matter, the relationship may terminate when the matter has been resolved, anticipated services have been completed, or the agreement has been violated.

4. Relationships

Whether a forensic practitioner–client relationship exists depends on the circumstances and is determined by a number of factors which may include the information exchanged between the potential client and the forensic practitioner prior to, or at the initiation of, any contact or service, the nature of the interaction, and the purpose of the interaction.

In their work, forensic practitioners recognize that relationships are established with those who retain their services (e.g., retaining parties, employers, insurers, the

court) and those with whom they interact (e.g., examinees, collateral contacts, research participants, students). Forensic practitioners recognize that associated obligations and duties vary as a function of the nature of the relationship.

Guideline 4.01: Responsibilities to Retaining Parties

Most responsibilities to the retaining party attach only after the retaining party has requested and the forensic practitioner has agreed to render professional services and an agreement regarding compensation has been reached. Forensic practitioners are aware that there are some responsibilities, such as privacy, confidentiality, and privilege, that may attach when the forensic practitioner agrees to consider whether a forensic practitioner–retaining party relationship shall be established. Forensic practitioners, prior to entering into a contract, may direct the potential retaining party not to reveal any confidential or privileged information as a way of protecting the retaining party's interest in case a conflict exists as a result of pre-existing relationships.

At the initiation of any request for service, forensic practitioners seek to clarify the nature of the relationship and the services to be provided including the role of the forensic practitioner (e.g., trial consultant, forensic examiner, treatment provider, expert witness, research consultant); which person or entity is the client; the probable uses of the services provided or information obtained; and any limitations to privacy, confidentiality, or privilege.

Guideline 4.02: Multiple Relationships

A multiple relationship occurs when a forensic practitioner is in a professional role with a person and, at the same time or at a subsequent time, is in a different role with the same person; is involved in a personal, fiscal, or other relationship with an adverse party; at the same time is in a relationship with a person closely associated with or related to the person with whom the forensic practitioner has the professional relationship; or offers or agrees to enter into another relationship in the future with the person or a person closely associated with or related to the person (EPPCC Standard 3.05).

Forensic practitioners strive to recognize the potential conflicts of interest and threats to objectivity inherent in multiple relationships. Forensic practitioners are encouraged to recognize that some personal and professional relationships may interfere with their ability to practice in a competent and impartial manner and they seek to minimize any detrimental effects by avoiding involvement in such matters whenever feasible or limiting their assistance in a manner that is consistent with professional obligations.

Guideline 4.02.01: Therapeutic–Forensic Role Conflicts

Providing forensic and therapeutic psychological services to the same individual or closely related individuals involves multiple relationships that may impair objectivity and/or cause exploitation or other harm. Therefore, when requested or ordered to provide either concurrent or sequential forensic and therapeutic services, forensic practitioners are encouraged to disclose the potential risk and make reasonable efforts to refer the request to another qualified provider. If referral is not possible, the forensic practitioner is encouraged to consider the risks and benefits to all parties and to the legal system or entity likely to be impacted, the possibility of separating each service widely in time, seeking judicial review and direction, and consulting with knowledgeable colleagues. When providing both forensic and therapeutic services, forensic practitioners seek to minimize the potential negative effects of this circumstance (EPPCC Standard 3.05).

Guideline 4.02.02: Expert Testimony by Practitioners Providing Therapeutic Services

Providing expert testimony about a patient who is a participant in a legal matter does not necessarily involve the practice of forensic psychology even when that testimony is relevant to a psycholegal issue before the decision maker. For example, providing testimony on matters such as a patient's reported history or other statements, mental status, diagnosis, progress, prognosis, and treatment would not ordinarily be considered forensic practice even when the testimony is related to a psycholegal issue before the decision maker. In contrast, rendering opinions and providing testimony about a person on psycholegal issues (e.g., criminal responsibility, legal causation, proximate cause, trial competence, testamentary capacity, the relative merits of parenting arrangements) would ordinarily be considered the practice of forensic psychology.

Consistent with their ethical obligations to base their opinions on information and techniques sufficient to substantiate their findings (EPPCC Standards 2.04, 9.01), forensic practitioners are encouraged to provide testimony only on those issues for which they have adequate foundation and only when a reasonable forensic practitioner engaged in similar circumstances would determine that the ability to make a proper decision is unlikely to be impaired. As with testimony regarding forensic examinees, the forensic practitioner strives to identify any substantive limitations that may affect the reliability and validity of the facts or opinions offered, and communicates these to the decision maker.

Guideline 4.02.03: Provision of Forensic Therapeutic Services

Although some therapeutic services can be considered forensic in nature, the fact that therapeutic services are ordered by the court does not necessarily make them forensic.

In determining whether a therapeutic service should be considered the practice of forensic psychology, psychologists are encouraged to consider the potential impact of the legal context on treatment, the potential for treatment to impact the psycholegal issues involved in the case, and whether another reasonable psychologist in a similar position would consider the service to be forensic and these Guidelines to be applicable.

Therapeutic services can have significant effects on current or future legal proceedings. Forensic practitioners

are encouraged to consider these effects and minimize any unintended or negative effects on such proceedings or therapy when they provide therapeutic services in forensic contexts.

Guideline 4.03: Provision of Emergency Mental Health Services to Forensic Examinees

When providing forensic examination services an emergency may arise that requires the practitioner to provide short-term therapeutic services to the examinee in order to prevent imminent harm to the examinee or others. In such cases the forensic practitioner is encouraged to limit disclosure of information and inform the retaining attorney, legal representative, or the court in an appropriate manner. Upon providing emergency treatment to examinees, forensic practitioners consider whether they can continue in a forensic role with that individual so that potential for harm to the recipient of services is avoided (EPPCC Standard 3.04).

5. Fees

Guideline 5.01: Determining Fees

When determining fees forensic practitioners may consider salient factors such as their experience providing the service, the time and labor required, the novelty and difficulty of the questions involved, the skill required to perform the service, the fee customarily charged for similar forensic services, the likelihood that the acceptance of the particularba employment will preclude other employment, the time limitations imposed by the client or circumstances, the nature and length of the professional relationship with the client, the client's ability to pay for the service, and any legal requirements.

Guideline 5.02: Fee Arrangements

Forensic practitioners are encouraged to make clear to the client the likely cost of services whenever it is feasible, and make appropriate provisions in those cases in which the costs of services is greater than anticipated or the client's ability to pay for services changes in some way.

Forensic practitioners seek to avoid undue influence that might result from financial compensation or other gains. Because of the threat to impartiality presented by the acceptance of contingent fees and associated legal prohibitions, forensic practitioners strive to avoid providing professional services on the basis of contingent fees. Letters of protection, financial guarantees, and other security for payment of fees in the future are not considered contingent fees unless payment is dependent on the outcome of the matter.

Guideline 5.03: Pro Bono Services

Forensic psychologists recognize that some persons may have limited access to legal services as a function of financial disadvantage and strive to contribute a portion of their professional time for little or no compensation or personal advantage (EPPCC Principle E).

6. Informed Consent, Notification, and Assent

Because substantial rights, liberties, and properties are often at risk in forensic matters, and because the methods and procedures of forensic practitioners are complex and may not be accurately anticipated by the recipients of forensic services, forensic practitioners strive to inform service recipients about the nature and parameters of the services to be provided (EPPCC Standards 3.04, 3.10).

Guideline 6.01: Timing and Substance

Forensic practitioners strive to inform clients, examinees, and others who are the recipients of forensic services as soon as is feasible about the nature and extent of reasonably anticipated forensic services.

In determining what information to impart, forensic practitioners are encouraged to consider a variety of factors including the person's experience or training in psychological and legal matters of the type involved and whether the person is represented by counsel. When questions or uncertainties remain after they have made the effort to explain the necessary information, forensic practitioners may recommend that the person seek legal advice.

Guideline 6.02: Communication With Those Seeking to Retain a Forensic Practitioner

As part of the initial process of being retained, or as soon thereafter as previously unknown information becomes available, forensic practitioners strive to disclose to the retaining party information that would reasonably be anticipated to affect a decision to retain or continue the services of the forensic practitioner.

This disclosure may include, but is not limited to, the fee structure for anticipated services; prior and current personal or professional activities, obligations, and relationships that would reasonably lead to the fact or the appearance of a conflict of interest; the forensic practitioner's knowledge, skill, experience, and education relevant to the forensic services being considered, including any significant limitations; and the scientific bases and limitations of the methods and procedures which are expected to be employed.

Guideline 6.03: Communication With Forensic Examinees

Forensic practitioners inform examinees about the nature and purpose of the examination (EPPCC Standard 9.03; American Educational Research Association, American Psychological Association, & National Council on Measurement in Education [AERA, APA, & NCME], in press). Such information may include the purpose, nature, and anticipated use of the examination; who will have access to the information; associated limitations on privacy, confidentiality, and privilege including who is authorized to release or access the information contained in the forensic practitioner's records; the voluntary or involuntary nature of participation, including potential consequences of par-

ticipation or nonparticipation, if known; and, if the cost of the service is the responsibility of the examinee, the anticipated cost.

Guideline 6.03.01: Persons Not Ordered or Mandated to Undergo Examination

If the examinee is not ordered by the court to participate in a forensic examination, the forensic practitioner seeks his or her informed consent (EPPCC Standards 3.10, 9.03). If the examinee declines to proceed after being notified of the nature and purpose of the forensic examination, the forensic practitioner may consider postponing the examination, advising the examinee to contact his or her attorney, and notifying the retaining party about the examinee's unwillingness to proceed.

Guideline 6.03.02: Persons Ordered or Mandated to Undergo Examination or Treatment

If the examinee is ordered by the court to participate, the forensic practitioner can conduct the examination over the objection, and without the consent, of the examinee (EPPCC Standards 3.10, 9.03). If the examinee declines to proceed after being notified of the nature and purpose of the forensic examination, the forensic practitioner may consider a variety of options including postponing the examination, advising the examinee to contact his or her attorney, and notifying the retaining party about the examinee's unwillingness to proceed.

When an individual is ordered to undergo treatment but the goals of treatment are determined by a legal authority rather than the individual receiving services, the forensic practitioner informs the service recipient of the nature and purpose of treatment, and any limitations on confidentiality and privilege (EPPCC Standards 3.10, 10.01).

Guideline 6.03.03: Persons Lacking Capacity to Provide Informed Consent

Forensic practitioners appreciate that the very conditions that precipitate psychological examination of individuals involved in legal proceedings can impair their functioning in a variety of important ways, including their ability to understand and consent to the evaluation process.

For examinees adjudicated or presumed by law to lack the capacity to provide informed consent for the anticipated forensic service, the forensic practitioner nevertheless provides an appropriate explanation, seeks the examinee's assent, and obtains appropriate permission from a legally authorized person, as permitted or required by law (EPPCC Standards 3.10, 9.03).

For examinees whom the forensic practitioner has concluded lack capacity to provide informed consent to a proposed, non-court-ordered service, but who have not been adjudicated as lacking such capacity, the forensic practitioner strives to take reasonable steps to protect their rights and welfare (EPPCC Standard 3.10). In such cases, the forensic practitioner may consider suspending the proposed service or notifying the examinee's attorney or the retaining party.

Guideline 6.03.04: Evaluation of Persons Not Represented by Counsel

Because of the significant rights that may be at issue in a legal proceeding, forensic practitioners carefully consider the appropriateness of conducting a forensic evaluation of an individual who is not represented by counsel. Forensic practitioners may consider conducting such evaluations or delaying the evaluation so as to provide the examinee with the opportunity to consult with counsel.

Guideline 6.04: Communication With Collateral Sources of Information

Forensic practitioners disclose to potential collateral sources information that might reasonably be expected to inform their decisions about participating that may include, but may not be limited to, who has retained the forensic practitioner; the nature, purpose, and intended use of the examination or other procedure; the nature of and any limits on privacy, confidentiality, and privilege; and whether their participation is voluntary (EPPCC Standard 3.10).

Guideline 6.05: Communication in Research Contexts

When engaging in research or scholarly activities conducted as a service to a client in a legal proceeding, forensic practitioners attempt to clarify any anticipated use of the research or scholarly product, disclose their role in the resulting research or scholarly products, and obtain whatever consent or agreement is required.

In advance of any scientific study, forensic practitioners seek to negotiate with the client the circumstances under and manner in which the results may be made known to others. Forensic practitioners strive to balance the potentially competing rights and interests of the retaining party with the inappropriateness of suppressing data, for example, by agreeing to report the data without identifying the jurisdiction in which the study took place. Forensic practitioners represent the results of research in an accurate manner (EPPCC Standard 5.01).

7. Conflicts in Practice

In forensic psychology practice, conflicting responsibilities and demands may be encountered. When conflicts occur, forensic practitioners seek to make the conflict known to the relevant parties or agencies, and consider the rights and interests of the relevant parties or agencies in their attempts to resolve the conflict.

Guideline 7.01: Conflicts With Legal Authority

When their responsibilities conflict with law, regulations, or other governing legal authority, forensic practitioners make known their commitment to the EPPCC, and take steps to resolve the conflict. In situations in which the

EPPCC or the Guidelines are in conflict with the law, attempts to resolve the conflict are made in accordance with the EPPCC (EPPCC Standard 1.02).

When the conflict cannot be resolved by such means, forensic practitioners may adhere to the requirements of the law, regulations, or other governing legal authority, but only to the extent required and not in any way that violates a person's human rights (EPPCC Standard 1.03).

Forensic practitioners are encouraged to consider the appropriateness of complying with court orders when such compliance creates potential conflicts with professional standards of practice.

Guideline 7.02: Conflicts With Organizational Demands

When the demands of an organization with which they are affiliated or for whom they are working conflict with their professional responsibilities and obligations, forensic practitioners strive to clarify the nature of the conflict and, to the extent feasible, resolve the conflict in a way consistent with professional obligations and responsibilities (EPPCC Standard 1.03).

Guideline 7.03: Resolving Ethical Issues With Fellow Professionals

When an apparent or potential ethical violation has caused, or is likely to cause, substantial harm, forensic practitioners are encouraged to take action appropriate to the situation and consider a number of factors including the nature and the immediacy of the potential harm; applicable privacy, confidentiality, and privilege; how the rights of the relevant parties may be affected by a particular course of action; and any other legal or ethical obligations (EPPCC Standard 1.04). Steps to resolve perceived ethical conflicts may include, but are not limited to, obtaining the consultation of knowledgeable colleagues, obtaining the advice of independent counsel, and conferring directly with the client.

When forensic practitioners believe there may have been an ethical violation by another professional, an attempt is made to resolve the issue by bringing it to the attention of that individual, if that attempt does not violate any rights or privileges that may be involved, and if an informal resolution appears appropriate (EPPCC Standard 1.04). If this does not result in a satisfactory resolution, the forensic practitioner may have to take further action appropriate to the situation, including making a report to third parties of the perceived ethical violation (EPPCC Standard 1.05). In most instances, in order to minimize unforeseen risks to the party's rights in the legal matter, forensic practitioners consider consulting with the client before attempting to resolve a perceived ethical violation with another professional.

8. Privacy, Confidentiality, and Privilege

Forensic practitioners recognize their ethical obligations to maintain the confidentiality of information relating to a client or retaining party, except insofar as disclosure is consented to by the client or retaining party, or required or permitted by law (EPPCC Standard 4.01).

Guideline 8.01: Release of Information

Forensic practitioners are encouraged to recognize the importance of complying with properly noticed and served subpoenas or court orders directing release of information, or other legally proper consent from duly authorized persons, unless there is a legally valid reason to offer an objection. When in doubt about an appropriate response or course of action, forensic practitioners may seek assistance from the retaining client, retain and seek legal advice from their own attorney, or formally notify the drafter of the subpoena or order of their uncertainty.

Guideline 8.02: Access to Information

If requested, forensic practitioners seek to provide the retaining party access to, and a meaningful explanation of, all information that is in their records for the matter at hand, consistent with the relevant law, applicable codes of ethics and professional standards, and institutional rules and regulations. Forensic examinees typically are not provided access to the forensic practitioner's records without the consent of the retaining party. Access to records by anyone other than the retaining party is governed by legal process, usually subpoena or court order, or by explicit consent of the retaining party. Forensic practitioners may charge a reasonable fee for the costs associated with the storage, reproduction, review, and provision of records.

Guideline 8.03: Acquiring Collateral and Third Party Information

Forensic practitioners strive to access information or records from collateral sources with the consent of the relevant attorney or the relevant party, or when otherwise authorized by law or court order.

Guideline 8.04: Use of Case Materials in Teaching, Continuing Education, and Other Scholarly Activities

Forensic practitioners using case materials for purposes of teaching, training, or research strive to present such information in a fair, balanced, and respectful manner. They attempt to protect the privacy of persons by disguising the confidential, personally identifiable information of all persons and entities who would reasonably claim a privacy interest; using only those aspects of the case available in the public domain; or obtaining consent from the relevant clients, parties, participants, and organizations to use the materials for such purposes (EPPCC Standard 4.07; also see Guidelines 11.06 and 11.07 of these Guidelines).

9. Methods and Procedures

Guideline 9.01: Use of Appropriate Methods

Forensic practitioners strive to utilize appropriate methods and procedures in their work. When performing examinations, treatment, consultation, educational activities, or scholarly investigations, forensic practitioners seek to

maintain integrity by examining the issue or problem at hand from all reasonable perspectives and seek information that will differentially test plausible rival hypotheses.

Guideline 9.02: Use of Multiple Sources of Information

Forensic practitioners ordinarily avoid relying solely on one source of data, and corroborate important data whenever feasible (AERA, APA, & NCME, in press). When relying upon data that have not been corroborated, forensic practitioners seek to make known the uncorroborated status of the data, any associated strengths and limitations, and the reasons for relying upon the data.

Guideline 9.03: Opinions Regarding Persons Not Examined

Forensic practitioners recognize their obligations to only provide written or oral evidence about the psychological characteristics of particular individuals when they have sufficient information or data to form an adequate foundation for those opinions or to substantiate their findings (EPPCC Standard 9.01). Forensic practitioners seek to make reasonable efforts to obtain such information or data, and they document their efforts to obtain it. When it is not possible or feasible to examine individuals about whom they are offering an opinion, forensic practitioners strive to make clear the impact of such limitations on the reliability and validity of their professional products, opinions, or testimony.

When conducting a record review or providing consultation or supervision that does not warrant an individual examination, forensic practitioners seek to identify the sources of information on which they are basing their opinions and recommendations, including any substantial limitations to their opinions and recommendations.

10. Assessment

Guideline 10.01: Focus on Legally Relevant Factors

Forensic examiners seek to assist the trier of fact to understand evidence or determine a fact in issue, and they provide information that is most relevant to the psycholegal issue. In reports and testimony, forensic practitioners typically provide information about examinees' functional abilities, capacities, knowledge, and beliefs, and address their opinions and recommendations to the identified psycholegal issues (American Bar Association & American Psychological Assocation, 2008; Grisso, 1986, 2003; Heilbrun, Marczyk, DeMatteo, & Mack-Allen, 2007).

Forensic practitioners are encouraged to consider the problems that may arise by using a clinical diagnosis in some forensic contexts, and consider and qualify their opinions and testimony appropriately.

Guideline 10.02: Selection and Use of Assessment Procedures

Forensic practitioners use assessment procedures in the manner and for the purposes that are appropriate in light of the research on or evidence of their usefulness and proper application (EPPCC Standard 9.02; AERA, APA, & NCME, in press). This includes assessment techniques, interviews, tests, instruments, and other procedures and their administration, adaptation, scoring, and interpretation, including computerized scoring and interpretation systems.

Forensic practitioners use assessment instruments whose validity and reliability have been established for use with members of the population assessed. When such validity and reliability have not been established, forensic practitioners consider and describe the strengths and limitations of their findings. Forensic practitioners use assessment methods that are appropriate to an examinee's language preference and competence, unless the use of an alternative language is relevant to the assessment issues (EPPCC Standard 9.02).

Assessment in forensic contexts differs from assessment in therapeutic contexts in important ways that forensic practitioners strive to take into account when conducting forensic examinations. Forensic practitioners seek to consider the strengths and limitations of employing traditional assessment procedures in forensic examinations (AERA, APA, & NCME, in press). Given the stakes involved in forensic contexts, forensic practitioners strive to ensure the integrity and security of test materials and results (AERA, APA, & NCME, in press).

When the validity of an assessment technique has not been established in the forensic context or setting in which it is being used, the forensic practitioner seeks to describe the strengths and limitations of any test results and explain the extrapolation of these data to the forensic context. Because of the many differences between forensic and therapeutic contexts, forensic practitioners consider and seek to make known that some examination results may warrant substantially different interpretation when administered in forensic contexts (AERA, APA, & NCME, in press).

Forensic practitioners consider and seek to make known that forensic examination results can be affected by factors unique to, or differentially present in, forensic contexts including response style, voluntariness of participation, and situational stress associated with involvement in forensic or legal matters (AERA, APA, & NCME, in press).

Guideline 10.03: Appreciation of Individual Differences

When interpreting assessment results, forensic practitioners consider the purpose of the assessment as well as the various test factors, test-taking abilities, and other characteristics of the person being assessed, such as situational, personal, linguistic, and cultural differences that might affect their judgments or reduce the accuracy of their interpretations (EPPCC Standard 9.06). Forensic practitioners strive to identify any significant strengths and limitations of their procedures and interpretations.

Forensic practitioners are encouraged to consider how the assessment process may be impacted by any disability an examinee is experiencing, make accommodations as

possible, and consider such when interpreting and communicating the results of the assessment (APA, 2011d).

Guideline 10.04: Consideration of Assessment Settings

In order to maximize the validity of assessment results, forensic practitioners strive to conduct evaluations in settings that provide adequate comfort, safety, and privacy.

Guideline 10.05: Provision of Assessment Feedback

Forensic practitioners take reasonable steps to explain assessment results to the examinee or a designated representative in language they can understand (EPPCC Standard 9.10). In those circumstances in which communication about assessment results is precluded, the forensic practitioner explains this to the examinee in advance (EPPCC Standard 9.10).

Forensic practitioners seek to provide information about professional work in a manner consistent with professional and legal standards for the disclosure of test data or results, interpretation of data, and the factual bases for conclusions.

Guideline 10.06: Documentation and Compilation of Data Considered

Forensic practitioners are encouraged to recognize the importance of documenting all data they consider with enough detail and quality to allow for reasonable judicial scrutiny and adequate discovery by all parties. This documentation includes, but is not limited to, letters and consultations; notes, recordings, and transcriptions; assessment and test data, scoring reports and interpretations; and all other records in any form or medium that were created or exchanged in connection with a matter.

When contemplating third party observation or audio/video-recording of examinations, forensic practitioners strive to consider any law that may control such matters, the need for transparency and documentation, and the potential impact of observation or recording on the validity of the examination and test security (Committee on Psychological Tests and Assessment, American Psychological Association, 2007).

Guideline 10.07: Provision of Documentation

Pursuant to proper subpoenas or court orders, or other legally proper consent from authorized persons, forensic practitioners seek to make available all documentation described in Guideline 10.05, all financial records related to the matter, and any other records including reports (and draft reports if they have been provided to a party, attorney, or other entity for review), that might reasonably be related to the opinions to be expressed.

Guideline 10.08: Record Keeping

Forensic practitioners establish and maintain a system of record keeping and professional communication (EPPCC Standard 6.01; APA, 2007), and attend to relevant laws and rules. When indicated by the extent of the rights, liberties, and properties that may be at risk, the complexity of the case, the amount and legal significance of unique evidence in the care and control of the forensic practitioner, and the likelihood of future appeal, forensic practitioners strive to inform the retaining party of the limits of record keeping times. If requested to do so, forensic practitioners consider maintaining such records until notified that all appeals in the matter have been exhausted, or sending a copy of any unique components/aspects of the record in their care and control to the retaining party before destruction of the record.

11. Professional and Other Public Communications

Guideline 11.01: Accuracy, Fairness, and Avoidance of Deception

Forensic practitioners make reasonable efforts to ensure that the products of their services, as well as their own public statements and professional reports and testimony, are communicated in ways that promote understanding and avoid deception (EPPCC Standard 5.01).

When in their role as expert to the court or other tribunals, the role of forensic practitioners is to facilitate understanding of the evidence or dispute. Consistent with legal and ethical requirements, forensic practitioners do not distort or withhold relevant evidence or opinion in reports or testimony. When responding to discovery requests and providing sworn testimony, forensic practitioners strive to have readily available for inspection all data which they considered, regardless of whether the data supports their opinion, subject to and consistent with court order, relevant rules of evidence, test security issues, and professional standards (AERA, APA, & NCME, in press; Committee on Legal Issues, American Psychological Association, 2006; Bank & Packer, 2007; Golding, 1990).

When providing reports and other sworn statements or testimony in any form, forensic practitioners strive to present their conclusions, evidence, opinions, or other professional products in a fair manner. Forensic practitioners do not, by either commission or omission, participate in misrepresentation of their evidence, nor do they participate in partisan attempts to avoid, deny, or subvert the presentation of evidence contrary to their own position or opinion (EPPCC Standard 5.01). This does not preclude forensic practitioners from forcefully presenting the data and reasoning upon which a conclusion or professional product is based.

Guideline 11.02: Differentiating Observations, Inferences, and Conclusions

In their communications, forensic practitioners strive to distinguish observations, inferences, and conclusions. Forensic practitioners are encouraged to explain the relationship between their expert opinions and the legal issues and facts of the case at hand.

Guideline 11.03: Disclosing Sources of Information and Bases of Opinions

Forensic practitioners are encouraged to disclose all sources of information obtained in the course of their professional services, and to identify the source of each piece of information that was considered and relied upon in formulating a particular conclusion, opinion, or other professional product.

Guideline 11.04: Comprehensive and Accurate Presentation of Opinions in Reports and Testimony

Consistent with relevant law and rules of evidence, when providing professional reports and other sworn statements or testimony, forensic practitioners strive to offer a complete statement of all relevant opinions that they formed within the scope of their work on the case, the basis and reasoning underlying the opinions, the salient data or other information that was considered in forming the opinions, and an indication of any additional evidence that may be used in support of the opinions to be offered. The specific substance of forensic reports is determined by the type of psycholegal issue at hand as well as relevant laws or rules in the jurisdiction in which the work is completed.

Forensic practitioners are encouraged to limit discussion of background information that does not bear directly upon the legal purpose of the examination or consultation. Forensic practitioners avoid offering information that is irrelevant and that does not provide a substantial basis of support for their opinions, except when required by law (EPPCC Standard 4.04).

Guideline 11.05: Commenting Upon Other Professionals and Participants in Legal Proceedings

When evaluating or commenting upon the work or qualifications of other professionals involved in legal proceedings, forensic practitioners seek to represent their disagreements in a professional and respectful tone, and base them on a fair examination of the data, theories, standards, and opinions of the other expert or party.

When describing or commenting upon clients, examinees, or other participants in legal proceedings, forensic practitioners strive to do so in a fair and impartial manner.

Forensic practitioners strive to report the representations, opinions, and statements of clients, examinees, or other participants in a fair and impartial manner.

Guideline 11.06: Out of Court Statements

Ordinarily, forensic practitioners seek to avoid making detailed public (out-of-court) statements about legal proceedings in which they have been involved. However, sometimes public statements may serve important goals such as educating the public about the role of forensic practitioners in the legal system, the appropriate practice of forensic psychology, and psychological and legal issues that are relevant to the matter at hand. When making public statements, forensic practitioners refrain from releasing private, confidential, or privileged information, and attempt to protect persons from harm, misuse, or misrepresentation as a result of their statements (EPPCC Standard 4.05).

Guideline 11.07: Commenting Upon Legal Proceedings

Forensic practitioners strive to address particular legal proceedings in publications or communications only to the extent that the information relied upon is part of a public record, or when consent for that use has been properly obtained from any party holding any relevant privilege (also see Guideline 8.04).

When offering public statements about specific cases in which they have not been involved, forensic practitioners offer opinions for which there is sufficient information or data and make clear the limitations of their statements and opinions resulting from having had no direct knowledge of or involvement with the case (EPPCC Standard 9.01).

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Appendix A
Revision Process of the Guidelines

This revision of the Guidelines was coordinated by the Committee for the Revision of the Specialty Guidelines for Forensic Psychology ("the Revisions Committee"), which was established by the American Academy of Forensic Psychology and the American Psychology–Law Society (Division 41 of the American Psychological Association [APA]) in 2002 and which operated through 2011. This committee consisted of two representatives from each organization (Solomon Fulero, PhD, JD; Stephen Golding, PhD, ABPP; Lisa Piechowski, PhD, ABPP; Christina Studebaker, PhD), a chairperson (Randy Otto, PhD, ABPP), and a liaison from Division 42 (Psychologists in Independent Practice) of APA (Jeffrey Younggren, PhD, ABPP).

This document was revised in accordance with APA Rule 30.08 and the APA policy document "Criteria for Practice Guideline Development and Evaluation" (APA, 2002). The Revisions Committee posted announcements regarding the revision process to relevant electronic discussion lists and professional publications (i.e., the Psylaw-L e-mail listserv of the American Psychology–Law Society, the American Academy of Forensic Psychology listserv, the American Psychology–Law Society Newsletter). In addition, an electronic discussion list devoted solely to issues concerning revision of the Guidelines was operated between December 2002 and July 2007, followed by establishment of an e-mail address in February 2008 (sgfp@yahoo.com). Individuals were invited to provide input and commentary on the existing Guidelines and proposed revisions via these means. In addition, two public meetings were held throughout the revision process at biennial meetings of the American Psychology–Law Society.

Upon development of a draft that the Revisions Committee deemed suitable, the revised Guidelines were submitted for review to the Executive Committee of the American Psychology–Law Society (Division 41 of APA) and the American Board of Forensic Psychology. Once the revised Guidelines were approved by these two organizations, they were submitted to APA for review, commentary, and acceptance, consistent with APA's "Criteria for Practice Guideline Development and Evaluation" (APA, 2002) and APA Rule 30-8. They were subsequently revised by the Revisions Committee and were adopted by the APA Council of Representatives on August 3, 2011.

(*Appendices continue*)

Appendix B
Definitions and Terminology

For the purposes of these Guidelines:

Appropriate, when used in relation to conduct by a forensic practitioner means that, according to the prevailing professional judgment of competent forensic practitioners, the conduct is apt and pertinent and is considered befitting, suitable, and proper for a particular person, place, condition, or function. ***Inappropriate*** means that, according to the prevailing professional judgment of competent forensic practitioners, the conduct is not suitable, desirable, or properly timed for a particular person, occasion, or purpose; and may also denote improper conduct, improprieties, or conduct that is discrepant for the circumstances.

Agreement refers to the objective and mutual understanding between the forensic practitioner and the person or persons seeking the professional service and/or agreeing to participate in the service. See also Assent, Consent, and Informed Consent.

Assent refers to the agreement, approval, or permission, especially regarding verbal or nonverbal conduct, that is reasonably intended and interpreted as expressing willingness, even in the absence of unmistakable consent. Forensic practitioners attempt to secure assent when consent and informed consent cannot be obtained or when, because of mental state, the examinee may not be able to consent.

Consent refers to agreement, approval, or permission as to some act or purpose.

Client refers to the attorney, law firm, court, agency, entity, party, or other person who has retained, and who has a contractual relationship with, the forensic practitioner to provide services.

Conflict of Interest refers to a situation or circumstance in which the forensic practitioner's objectivity, impartiality, or judgment may be jeopardized due to a relationship, financial, or any other interest that would reasonably be expected to substantially affect a forensic practitioner's professional judgment, impartiality, or decision making.

Decision Maker refers to the person or entity with the authority to make a judicial decision, agency determination, arbitration award, or other contractual determination after consideration of the facts and the law.

Examinee refers to a person who is the subject of a forensic examination for the purpose of informing a decision maker or attorney about the psychological functioning of that examinee.

Forensic Examiner refers to a psychologist who examines the psychological condition of a person whose psychological condition is in controversy or at issue.

Forensic Practice refers to the application of the scientific, technical, or specialized knowledge of psychology to the law and the use of that knowledge to assist in resolving legal, contractual, and administrative disputes.

Forensic Practitioner refers to a psychologist when engaged in forensic practice.

Forensic Psychology refers to all forensic practice by any psychologist working within any subdiscipline of psychology (e.g., clinical, developmental, social, cognitive).

Informed Consent denotes the knowledgeable, voluntary, and competent agreement by a person to a proposed course of conduct after the forensic practitioner has communicated adequate information and explanation about the material risks and benefits of, and reasonably available alternatives to, the proposed course of conduct.

Legal Representative refers to a person who has the legal authority to act on behalf of another.

Party refers to a person or entity named in litigation, or who is involved in, or is witness to, an activity or relationship that may be reasonably anticipated to result in litigation.

Reasonable or ***Reasonably***, when used in relation to conduct by a forensic practitioner, denotes the conduct of a prudent and competent forensic practitioner who is engaged in similar activities in similar circumstances.

Record or ***Written Record*** refers to all notes, records, documents, memorializations, and recordings of considerations and communications, be they in any form or on any media, tangible, electronic, handwritten, or mechanical, that are contained in, or are specifically related to, the forensic matter in question or the forensic service provided.

Retaining Party refers to the attorney, law firm, court, agency, entity, party, or other person who has retained, and who has a contractual relationship with, the forensic practitioner to provide services.

Tribunal denotes a court or an arbitrator in an arbitration proceeding, or a legislative body, administrative agency, or other body acting in an adjudicative capacity. A legislative body, administrative agency, or other body acts in an adjudicative capacity when a neutral official, after the presentation of legal argument or evidence by a party or parties, renders a judgment directly affecting a party's interests in a particular matter.

Trier of Fact refers to a court or an arbitrator in an arbitration proceeding, or a legislative body, administrative agency, or other body acting in an adjudicative capacity. A legislative body, administrative agency, or other body acts in an adjudicative capacity when a neutral official, after the presentation of legal argument or evidence by a party or parties, renders a judgment directly affecting a party's interests in a particular matter.

Association of Family and Conciliation Courts

Guidelines for Court-Involved Therapy

Association of Family and Conciliation Courts

Guidelines for Court-Involved Therapy

Approved by the AFCC Board of Directors
October 2010

Table of Contents

PREAMBLE

The Guidelines for Court-Involved Therapy have been formulated to assist members of the Association of Family and Conciliation Courts (AFCC) and others who provide treatment to court-involved children and families. The Guidelines are also intended to assist those who rely on mental health services or on the opinions of mental health professionals in promoting effective treatment and assessing the quality of treatment services. The Guidelines are also intended to assist the Courts to develop clear and effective Court orders and parenting plans that may be necessary for treatment to be effective.

AFCC does not intend these Guidelines to define mandatory practice. They are a best-practice guide for therapists, attorneys, other professionals and judicial officers when there is a need for therapeutic interventions with court-involved children or parents. While available resources and local jurisdictional expectations may influence the types of therapeutic services provided by a Court-Involved Therapist (CIT), the purpose of these guidelines is to educate, highlight common concerns, and to apply relevant ethical and professional guidelines, standards, and research in handling court-involved families.

INTRODUCTION

For the purposes of these guidelines, court-involved therapists are mental health professionals who provide therapeutic services to family members involved in child custody or juvenile dependency Court processes. Family and juvenile Court cases involving therapeutic services introduce unique factors and dynamics that require consideration in the treatment process. Both the treatment process and information provided to the therapist are likely to be influenced by the family's involvement in a legal process. While appropriate treatment can offer considerable benefit to children and families, inappropriate treatment may escalate family conflict and cause significant damage.

The Guidelines for Court-Involved Therapy are the product of the Court-Involved Therapist Task Force, appointed by AFCC President Robin Deutsch in 2009. Task force members were: Hon. Linda S. Fidnick, Co-Chair; Matthew Sullivan, Ph.D., Co-Chair; Lyn R. Greenberg, Ph.D., Reporter; Paul Berman, Ph.D.; Christopher Barrows, J.D.; Hon. R. John Harper; Hon. Anita Josey-Herring; Mindy Mitnick, M.Ed., M.A.; and Hon. Gail Perlman.

DEFINITIONS

A. Definitions Regarding Professional Roles

Community Therapist: Any mental health professional providing psychotherapeutic treatment of a parent, child, couple or family who is not involved with the legal system at any time during the treatment.

Court-Involved Therapist (CIT): Any mental health professional providing psychotherapeutic treatment of a parent, child, couple or family who is, at any time during the treatment, involved with the legal system.

Court-Appointed Therapist: Any mental health professional providing psychotherapeutic treatment of a parent, child, couple or family undertaken because the particular psychotherapist was ordered by a judge to provide treatment. The Court order designates the specific psychotherapist and may describe the expected treatment.

Court-Ordered Therapist: Any mental health professional providing psychotherapeutic treatment of a parent, child, couple or family undertaken because it was ordered by a judge. The Court order does not designate a specific therapist and may describe the expected treatment.

B. Definitions Regarding Experts

Expert: The word expert generally refers to a person with specialized knowledge of a particular subject matter.

In the legal context, the word "expert" refers to a witness who has been specifically qualified by the Court in a particular case to provide opinion evidence within a circumscribed subject matter determined by the Court. To qualify an expert, the Court first reviews evidence of the witness's expertise of that subject matter, unless the admissibility of the professional's opinion as an expert has been previously stipulated to by the parties or established by the Court.

(a) Treating Expert: A mental health professional, who currently serves or has served as the therapist for a parent, child, couple or family involved with the legal system. If the therapist is qualified by the Court as an expert, testimony should be limited to the therapist's particular area of expertise and issues directly relevant to the treatment role. To the degree permitted by the Court in a specific case, the treating expert can provide expert opinion regarding a parent or child's psychological functioning over time, progress, relationship dynamics, coping skills, development, co-parenting progress, or need for further treatment, as appropriate to the therapist's role. In contrast to the forensic expert, the treating expert does not have the information base or objectivity necessary to make psycho-legal recommendations, such as specifying parenting plans, legal custody, or decision-making authority.

(b) Mental Health Forensic Expert: A mental health professional hired by a party or appointed by a Court to answer a legal question through the application of psychological methods. A mental health forensic expert, for example, may perform a custody evaluation, a psychological evaluation to answer a particular question formulated by the Court, a competency evaluation, an evaluation to assist the Court in the decision-making process regarding custody and/or access. Their testimony might include psycho-legal issues such as recommendations about parenting plans, legal custody or decision-making authority.

C. General Definitions

Client/Patient: A parent, child, couple or family receiving psychotherapeutic treatment from any of the mental health professionals defined in this section

Collateral: A person, not a client or patient, who has information bearing on the client or patient and whom a mental health professional, in any role defined in this section, interviews to obtain information or engages directly in the client or patient's treatment.

Confidentiality: An ethical duty, also established by statute, rules or case law in some jurisdictions, owed by a mental health professional to a client/patient, subject to some exceptions, to maintain the client/patient's privacy by not revealing information received from the client/patient.

Privilege: A legal right, conferred by statute in many jurisdictions and limited by exceptions, held by a mental health professional's client/patient to prevent the mental health professional from disclosing confidential information in a legal proceeding. Some jurisdictions have a formal process for determining whether or not and under what circumstances the privilege will be waived by or on behalf of the client/patient to allow testimony by the mental health professional in a court-related matter. (Issues regarding privilege and confidentiality are described in Guideline 7.)

Conflict of Interest: A situation in which personal, professional, legal or other interests or relationships have the potential to compromise or bias the mental health professional's judgment, effectiveness or objectivity. A conflict of interest may also occur in some jurisdictions based on the establishment of an appearance of conflict standard rather than an actual conflict.

Informed Consent:

(a) A client/patient's decision to consent to a proposed treatment or a proposed release of confidential information by a mental health professional, after the client/patient has received reasonably full and accurate information from the mental health professional as to the risks, benefits and likely consequences of the decision to consent.

(b) The term is used colloquially by mental health professionals to mean the *process* by which a client/patient receives the information needed to make an informed decision. The process usually includes discussion and a written agreement between the mental health professional and the client/patient as to the information provided and the client's understanding of it. (See Guideline 6.)

GUIDELINE 1: ASSESSING LEVELS OF COURT INVOLVEMENT

1.1 A CIT should assess the degree to which legal processes will impact the treatment and consider issues that may impact the client or parent's functioning in treatment, and the implications of treatment interventions on the legal processes

(a) The CIT should be aware that cases may have different degrees of Court involvement, and may also change in their degree of Court involvement over time.

(b) The CIT should obtain information about how the decision to enter therapy was made, who was involved in the decision, and what outcomes are expected from the treatment or the therapist by parents, other professionals, or the Court.

(c) The CIT should consider the variety of mechanisms through which court-involved families can enter treatment, and the implications of each of those circumstances:

(1) A parent involved in a Court case recognizes his/her own or child's distress and seeks treatment.
(2) A parent seeks therapy for him/herself or a child, in hopes of improving his/her own position in the Court case and securing the therapist's direct or indirect participation (report to a custody evaluator, etc.).
(3) Parents are ordered to obtain therapy for themselves or a child, but select from community practitioners with no specific agenda, reporting expectation or requirement.
(4) The Court orders therapy to address particular issues, such as child distress, high-conflict dynamics, reunification, etc. The order may include some degree of reporting requirement, or contingencies allowing reporting.

(d) The CIT should consider the potential impact of Court involvement on adults' functioning in treatment. The stress of Court involvement and the importance of the outcome to those involved can generate conscious or unconscious distortion of information and changes in the clients' or parents' expectations of the therapist.

(e) The CIT should consider the impact of his/her natural working alliance with the client. This may lead the therapist to align with the client's position in the legal dispute, thus impairing the CIT's ability to prepare the client to cope with likely outcomes and stresses in the legal process. While a client may equate his or her best interests with prevailing in the legal dispute, CITs must remain cognizant that their role is to promote successful psychological

functioning in the client, not to serve as an advocate or a forensic expert or produce a particular outcome in the legal process.

1.2. Special considerations for court-involved roles with children

(a) Children's behavior and statements may vary markedly based on the circumstances of treatment.

(b) The CIT has an enhanced obligation to consider multiple treatment hypotheses and be knowledgeable about children's developmental tasks and needs.

(c) The CIT should use particular caution to ensure that he/she has adequate data on which to base any opinions or assessments, and to form and express such opinions only within confines of the therapeutic role and available information, while remaining cognizant of the impact of Court involvement on the family and on treatment information.

(d) The CIT must, whenever possible, obtain each parent's perspective in the treatment process and maintain professional objectivity when interpreting statements and behaviors of children. The CIT should use particular caution in interpreting statements, play or drawings that appear to express positions on adult issues to avoid inaccurate or incomplete assessment of a child's developmental needs, expressed thoughts and feelings.

(e) The CIT should be aware of the potential impact of parental needs and expectations on treatment involving children or adolescents. The CIT should be particularly aware that:

  (1) A parent may have a genuine desire to obtain treatment or provide it to a child, but may also have expectations that the therapy will support the parent's own goals in the legal conflict.
  (2) A child or adolescent who is expressing a "position" regarding a contested issue in the legal conflict may have external influences on their perceptions, or that negatively impact their coping skills.

(f) While it is common in traditional treatment for one parent to be more involved in child treatment than the other, this therapy structure creates a risk in court-involved treatment. A CIT should consider *both* parent-child relationships and each parent's perspective in court-involved treatment.

GUIDELINE 2: PROFESSIONAL RESPONSIBILITIES

2.1 A CIT should establish and maintain appropriate role boundaries

(a) A CIT should inform potential clients, and others who may be relying on the therapist's opinion or services, of the nature of the services that can be offered by the therapist and the limits thereof. This includes providing thorough informed consent to clients/parents and appropriate information to others who may rely on the therapist's information. (See Guideline 6 and Guideline 10.)

(b) A CIT should resist pressure from anyone to provide services beyond or antithetical to the therapeutic role, as defined by recognized professional and ethical standards or guidelines.

(c) A CIT should explain to clients any decisions to decline to provide certain services. If others (e.g., the Court guardian *ad litem*, minor's counsel or agency) have requested services that the CIT considers inappropriate, the CIT should also explain decisions to decline these requests, to the degree that information provided is not privileged or privilege has been waived.

(d) A CIT should be prepared to modify elements of the therapeutic process, if appropriate, and to explain the necessity for the modification.

(e) A CIT should apprise the Court of any conflicts between the Court's expectations and the ethical and professional obligations, or role limitations, of the therapist.

2.2 A CIT should demonstrate respect for parties, families, the legal process and its participants

(a) A CIT should communicate respect for the legal system to clients, collaterals, and others who may rely on the therapist's work, information or opinions.

(b) A CIT should provide a thorough informed consent processes to parents, and age-appropriate explanations to children, as described in Guideline 6.

(c) A CIT should communicate, within the limits of any applicable privilege, regarding the limits and responsibilities of the therapist's role.

(d) A CIT should respect each parent's rights, as defined by relevant orders or law, regarding knowledge of, consenting to, and/or participating in a child's treatment.

(e) A CIT should be knowledgeable about appropriate expectations for developmentally acceptable behavior in children while respecting their independent feelings, perceptions, and developmental needs.

(f) A CIT should communicate with counsel in a balanced manner when in a neutral role and authorized to do so.

2.3 A CIT should provide clear, non-technical communication of observations and opinions to adult clients, parents of child clients, and other professionals when appropriate and permitted by applicable privilege

2.4 A CIT should maintain professional objectivity

(a) A CIT should actively seek information that will provide the most thorough understanding of his/her client's circumstances and issues, while remaining within the limits of the therapist's assigned therapeutic role in the case.

(b) When children are involved in treatment, a CIT has an enhanced obligation to consider multiple hypotheses, seek information and involvement from both parents and avoid the biasing effects of one-sided or limited information.

(c) A CIT should make efforts to consider and assess treatment issues from the perspective of each involved individual. This does not preclude maintaining a strong therapeutic alliance with a parent client/patient in individual therapy, but may require exploring with the client how others may perceive the issues.

(d) To the degree possible in the given therapeutic role, the CIT should remain aware of the information emerging in the legal process in order to assist the client in coping with it.

2.5 The CIT should manage relationships responsibly

(a) A CIT should recognize that the therapeutic relationship may change as a family's involvement with the Court changes or as the therapist communicates to other professionals, collaterals or the Court.

(b) If a parent or family who has not previously been court-involved becomes involved in a legal process and asks the therapist to continue services, the CIT should discuss with the relevant individuals and/or family members the potential effect of Court involvement on the therapy. This should include discussion of potential requests for release of therapeutic information to others including a child custody evaluator, parenting coordinator, other professionals, or the Court.

(c) If a CIT who has not previously been involved with a client's ongoing litigation is asked to provide information or have other involvement in the legal process, the CIT should notify the client and/or the client's legal representative of such requests. If the CIT believes the release of information

will adversely impact the client, the CIT should seek legal advice and notify the Court.

(d) The CIT should clearly document informed consent on the above issues.

2.6 A CIT should maintain accountability

(a) The therapist in a child-centered role should recognize that active intervention may result in the dissatisfaction of one or both parents, but should nevertheless maintain focus on the welfare of the child client.

(b) If disputes arise regarding interpretation of Court orders governing treatment, the CIT should seek direction or clarification from the Court, or an authorized Court representative in the case.

(c) The CIT should recognize that others in the legal system (e.g., custody evaluator, parenting coordinator, child's counsel or the Court) may have a role in monitoring or reviewing the therapeutic process.

(d) The CIT should recognize that his/her judgments, interventions, reports, testimony and opinions may have a profound impact on outcomes for children and families. The CIT should remain objective at all times, should use caution in forming and expressing opinions, and should use particular caution in drawing conclusions from limited observations or sources of information.

(e) A CIT should recognize that the dynamics of a court-involved case may create conflicts or disagreements with litigating parents or lead to demands that the therapist withdraw from the case. The CIT should recognize that therapeutic confrontation of a parent or a child, or a refusal to accede to the wishes of a parent or child, may frustrate that individual's desires, but does not necessarily constitute a conflict of interest. Such therapeutic confrontation may be therapeutically appropriate or even essential. In such a situation, withdrawing from the case or abandoning the intervention, unless terminated by the client, may be antithetical to the interest of the child or family.

GUIDELINE 3: COMPETENCE

3.1 A CIT has a responsibility to develop and maintain specialized competence sufficient for the roles they undertake

3.2 Gaining and maintaining competence

(a) A CIT has a responsibility to obtain education and training, and to maintain current knowledge, in areas including, but not limited to:

(1) Characteristics of divorcing/separated families and children

(2) Family systems and other systems in which court-involved families interact
(3) The impact of high interparental conflict on post-separation custody arrangements
(4) Effective interventions with divorcing or separated families
(5) Adaptations of traditional therapeutic approaches that may be Necessary to work with divorcing or separated families
(6) characteristics and needs of special populations who may be Involved in treatment
(7) Ethical issues and applicable local legal standards

(b) A CIT should utilize continuing education and professional development resources to maintain current knowledge of issues relevant to court-involved treatment.

(c) A CIT may also gain some of the required knowledge through experience and consultation with colleagues; however, clinical experience should not be a substitute for knowledge of the underlying science, relevant research, legal issues and standards of practice.

3.3 Areas of competence

(a) The CIT should maintain knowledge and familiarity with current research related to psychological issues in areas including, but not limited to:

(1) Child development and coping, including developmental tasks
(2) Child interviewing and suggestibility
(3) Children's decision-making ability, including appropriate means of understanding children's abilities and interpreting expressed preferences or opinions
(4) Factors in divorcing families that increase risk to children, or promote resilience in children
(5) Domestic violence
(6) Child abuse and child welfare
(7) High conflict dynamics, including risks to children from exposure to parental conflict, parental undermining, alienation and estrangement
(8) Treatment approaches, including both traditional methods and adaptations for divorcing or separated families
(9) Parenting and behavioral interventions
(10) Special needs issues, including medical issues, psychiatric diagnoses, substance abuse, learning or educational problems, developmental delays, etc.
(11) Ethnic, cultural, and sexual orientation differences among families

(b) The CIT should maintain knowledge and familiarity with legal information and issues related to court-involved therapy, including, but not limited to:

(1) Statutes and local Court rules in the therapist's jurisdiction
(2) Case precedents relevant to court-involved treatment
(3) Interactions and potential conflicts between governing mental health practice and family Court expectations or family law statues
(4) Ethical and professional guidelines and standards applicable to the role of the CIT, obtaining ethics consultation as appropriate
(5) Circumstances under which it may be necessary or appropriate for the therapist to consult an attorney

(c) The CIT should seek appropriate consultations when issues arise that are outside of the CIT's expertise.

3.4 Understanding of professional roles and resources

(a) The CIT should be familiar with the roles of other professionals with whom the CIT may interface while providing therapy in a case.

(b) The CIT should understand the roles of the child custody evaluator and the parenting coordinator, and the impact that the appointment of such professionals may have on both the process of therapy and the privacy of therapeutic information.

(c) The CIT should understand the roles of the minor's counsel or guardian *ad litem*, and should be aware of the laws governing confidentiality of treatment information when one of these professionals is appointed.

3.5 Representation of competence, state of professional knowledge

(a) The CIT should accurately represent his/her areas of competence, advise clients/parents if an issue arises that is beyond the CIT's knowledge and expertise, and initiate consultation and/or referral, when appropriate.

(b) The CIT should understand the limits of scientific knowledge and use caution to avoid overstating the certainty or parameters of professional opinions. (See Guideline 10.)

3.6 Consideration of impact of personal beliefs and experiences

(a) The CIT should remain familiar with current research on the impact of personal bias, personal beliefs and cultural and value differences, factors that may contribute to bias, and efforts that may be undertaken to contain or manage potentially biasing conditions in the CIT's work.

(b) The CIT should recognize and acknowledge that powerful issues may arise in court-related cases that generate personal reactions in the therapist or others, and take steps to counterbalance exposure to information or otherwise manage these issues.

(c) The CIT should obtain appropriate consultation to assist in maintaining professional objectivity.

GUIDELINE 4: MULTIPLE RELATIONSHIPS

4.1 The CIT should avoid serving simultaneously in multiple roles, particularly if these create a conflict of interest. For example, the CIT should not serve simultaneously as therapist and evaluator or as therapist and friend. Similarly, the CIT is strongly discouraged from performing different roles sequentially, as, for example, a therapist who becomes an evaluator or a therapist who becomes a parenting coordinator.

4.2 The CIT should disclose to all relevant parties any multiple relationships that cannot be avoided and the potential negative impact of such multiple roles.

(a) The CIT who discovers that he/she is performing multiple roles in a case should promptly seek to resolve any conflicts in a manner that is least harmful to the client and family. The CIT should clarify the expectations of each role and seek to avoid or minimize the negative impact of assuming multiple roles.

(b) The CIT should recognize that relationships with clients are not time limited and that prior relationships, or the anticipation of future relationships, may have an adverse effect on the CIT's ability to be objective.

(c) The CIT should attempt to avoid conflicts of interest and should address them as soon as they arise, or the potential for conflict becomes known, by:

(1) Identifying a real or apparent conflict of interest as soon as it becomes known to the CIT
(2) Refusing to assume a therapeutic role if personal, professional, legal, financial or other interests or relationships could reasonably be expected to impair objectivity, competence or effectiveness in the provision of services
(3) Communicating with the client or potential client or counsel, and, if necessary, with the Court, about the existence of the conflict.
(4) Recognizing that the appearance of a conflict of interest, as well as an actual conflict of interest, can diminish public trust and confidence both in the therapeutic service and in the Court
(5) Differentiating between conflicts that require declining to assume or

withdrawing from the therapeutic role, as opposed to multiple or sequential roles that may be undertaken with waivers from the client or parent

(6) Recognizing the risks of undertaking conflicting roles, even if the client or parent signs a waiver

(7) Clearly documenting the disclosure of any waived conflict, the client's ability to understand it, and the client's waiver. The client must receive a clear explanation of the conflict, and it may also be necessary to provide such explanations to other professionals or agencies relying on the therapist's work or information

GUIDELINE 5: FEE ARRANGEMENTS

5.1 The CIT should establish a clear written fee agreement with the responsible parties prior to commencing the treatment relationship

(a) A CIT may send a written fee agreement to the parties and/or client(s) prior to commencing treatment.

(b) If the case is not court-involved, a CIT may discuss the terms and fee requirements of treatment directly with the parties and/or client. This discussion should be documented in the CIT's record.

(c) If the case is already court-involved, or likely to be, a CIT may send the fee and consent agreements to counsel.

5.2 The CIT should provide written documentation to each responsible party

(a) Documentation should include a description of the treatment services to be provided, including all of the elements of informed consent described in Guideline 6.

(b) A CIT should provide a fee agreement that contains, at a minimum:

(1) A description of all services and charges

(2) Expectations regarding payment, including, if applicable:
   (i) fees associated with missed or cancelled sessions,
   (ii) costs/fees generated by one parent,
   (iii) consequences of non-payment, including its potential impact on continued provision of services,
   (iv) the use of collection agencies or other legal measures that may be taken to collect the fee (see attached sample agreement).

(3) Policies with regard to insurance reimbursement, if any. This should include issues such as identifying the person responsible for submitting the insurance form, payment for covered and non-covered

services, responsibility for submitting treatment plans (if required by the insurer) and the consequences of using insurance.

(4) Policies regarding advance payments, if any, for treatment services and the use of those payments

(5) A procedure for handling of disputes regarding payment

(c) If the therapy is court-ordered, the CIT should provide to the Court all information required to engage the CIT so that the Court can issue an appropriate and comprehensive order. The written fee agreement may be incorporated into the Court order that initiates the therapy. The therapist should request that the Court specify the party responsible for the payment or the specific apportionment between the parents or parties. In the event that the Court order fails to address the issue of fees adequately, the therapist should take appropriate steps to obtain clarification from the Court before providing services. Arrangements should be sufficiently clear to prevent or resolve most fee-related disputes, and for a future judicial officer or reviewer to be able to resolve any such disputes submitted to the Court.

(d) If treatment is terminated or suspended due to non-payment, the CIT should conduct the termination or suspension in accordance with the order, fee agreement and ethical principles.

(e) The CIT should maintain complete and accurate written records of all amounts billed and all amounts paid.

GUIDELINE 6: INFORMED CONSENT

6.1 At the outset of therapy, the CIT should provide a thorough informed consent process to adult clients and parents or legal guardians if the therapy involves the child

(a) A CIT has a professional obligation to inform the client of the limits of confidentiality and privilege at the outset of the therapeutic relationship, to promote informed decision-making throughout treatment and to document such explanations in the CIT's record. The CIT should clarify that these cautions do not constitute legal advice, and that the CIT will obey the Court's orders regarding treatment information.

(b) The informed consent should use language that is understandable and includes, at a minimum, information about the nature and anticipated course of the therapy, risks and benefits of the therapy, fees, the potential involvement of other individuals in the therapy, and a discussion of confidentiality.

(c) The CIT should be aware of state laws that impact confidentiality and access to records and these should be incorporated in the informed consent.

(d) Clients or their counsel should have an opportunity to ask questions, obtain answers, and discuss their concerns. These discussions should be documented in the CIT's record.

6.2 If a child is to be involved in treatment, there are special considerations

(a) A CIT should generally avoid accepting a child into treatment without notifying or consulting with both parents.

(b) A CIT should request copies of Court orders or custody judgments documenting each parent's right/authority to make decisions regarding treatment and delineation of each parent's access to treatment information.

(c) In rare and urgent cases, such as when there is strong reason to suspect a risk to a child's safety, a CIT may accept a child in treatment at the request of one parent. This should only occur if that parent has clear legal authority to consent and pending efforts to either notify the other parent or obtain permission from the Court; however, the CIT should be aware that such a decision may increase risk to the child, and to the CIT.

(d) A CIT should explain the nature and purpose of the treatment to a child in age-appropriate language. It may be necessary to revisit these issues as treatment proceeds.

(e) A CIT should discuss the limits of parental involvement and confidentiality with the parents or guardians of a child or adolescent involved in treatment.

6.3 When a CIT becomes involved in treatment at the request of a third party such as the Court, an attorney, or a social service agency, the CIT should be especially attentive to informed consent issues

(a) The CIT should identify to the client the name of the person or agency that requested the services and the potential impact this may have on the treatment.

(b) If an adult client or parent does not sign the informed consent, or otherwise has significant disagreements with the treatment process, the CIT should defer commencement of services and refer the client back to the third party agency or the Court for clarification.

(c) If the CIT has been appointed by the Court to provide treatment to one or more adults and an adult refuses to sign consent documents, the CIT should defer commencement of services until consent is obtained or the Court takes action to resolve the issue.

(d) If a CIT is asked by anyone to provide treatment to a child and one parent supports treatment while the other refuses consent, the therapist should refer the parties back to the Court for resolution of the dispute between the parents, and then proceed as the Court directs.

(e) If the court-ordered treatment is to proceed, it is recommended that the CIT require a treatment order, specifying the nature of the services to be provided and the parameters of treatment, before proceeding with treatment.

6.4 When more than one individual participates in the therapy, the CIT should clarify with each person the nature of the relationship between the participants and between each participant and the therapist. The CIT should also clarify his/her roles and responsibilities, the anticipated use of information provided by each person, and the extent and limits of confidentiality and privilege

6.5 On a case-specific basis, the CIT should explain to the client the manner in which treatment information will be handled. Issues to be clarified may include, but are not limited to:

(a) Whether the consent of one or both parents will be required to release information from conjoint, co-parenting or marital therapy

(b) Whether information will be released to a custody evaluator, parenting coordinator, the Court, or any other individual, and the extent of the information to be released

(c) Whether, and how, the CIT will communicate to the Court in the event that one or both parents do not cooperate with court-ordered treatment

(d) What will happen if the CIT is subpoenaed to give testimony in a court-related matter

(e) What information can be released to insurance companies, the Court, the other parent, or other entities to enable the CIT to collect his/her fees.

6.6 The parent/client should be encouraged to consult with counsel before signing a therapy/informed consent agreement, if the parent or client is represented

6.7 If the CIT's level of Court involvement changes or requests are made to change the CIT's role, the CIT should inform the client of the risks, benefits and impact of any potential changes in treatment

(a) The CIT should obtain consultation before contemplating a change in his/her role that might create a conflict of interest or alter therapeutic alliances.

(b) If the CIT becomes aware of potentially conflicting roles, he/she should take reasonable steps to immediately disclose, clarify and discuss the potential conflicts and any potential adverse impact. The CIT should make best efforts to minimize any negative impact, including withdrawing from the case, if appropriate.

(c) If the parties consent to a change in the CIT's role, the CIT should document the revised informed consent process.

6.8 The CIT should be sensitive to the possibility of being asked to provide feedback to third parties or to testify as a witness. The CIT should inform the client of this potential at the beginning of the informed consent process and as necessary thereafter.

(a) The CIT should take reasonable steps to clarify the limits of the therapeutic role, the potential scope of information to be released, and the potential implications of the release of information or the testimony for the client (see Guideline 7). In no case should the CIT attempt to provide legal advice to the client.

GUIDELINE 7: PRIVACY, CONFIDENTIALITY AND PRIVILEGE

7.1 The CIT should understand the principal issues that arise in court-related therapy in regard to client/patient confidentiality and privilege.

(a) The CIT should be aware that laws and standards vary markedly among jurisdictions, and there may be conflicts in the law within a single jurisdiction. Issues that may vary among (and within) jurisdictions include, but are not limited to:

(1) The identified client
(2) Assertion and waiver of the client's privilege
(3) Under what circumstances the mental health professional can or must disclose confidential information

(b) The CIT should be aware that ethical, clinical, and legal issues related to confidentiality/privilege may differ depending on whether a parent, child, couple or family is in treatment.

(c) The CIT should be aware of clinical issues related to disclosure of confidential information. (See Guideline 8.7.)

7.2 The impact of litigation on decisions regarding use of treatment information.

(a) The CIT should also be aware that a client or parent's legal case may be affected by the client's decision to release or decline to release treatment information. The CIT should encourage the client/parent to seek appropriate legal consultation before making this decision.

(b) The CIT should consider the impact of the Court context on a client's decisions about the use of treatment information and should take precautions accordingly.

(c) The CIT should consider that situational pressures may affect the client or parent's judgment or authority on the issue of waiving the privilege regarding treatment information. These pressures may include requests from the Court or other professionals with influence on the legal proceedings (e.g., a custody evaluator or parenting coordinator) that the parent waive his/her own, or the child's privilege as to the treatment relationship.

(d) The CIT should be aware that in some jurisdictions or situations, parents may not hold the right to waive or assert the child's privilege in court-involved treatment or treatment of the child. In some jurisdictions, a CIT has the option or duty to resist disclosure of information, or seek direction from the Court, if the CIT determines that disclosure of the information risks the welfare of the child. The CIT should be familiar with the appropriate procedures for his/her jurisdiction.

7.3 A CIT should recognize the limits of his/her expertise and, when in doubt as to whether information requested about treatment can be released, seek legal advice or request direction from the Court

7.4 Ongoing obligation to inform clients

(a) A CIT should revisit the discussion of confidentiality with the client as circumstances change, or as issues arise in therapy that may result in the disclosure of treatment information.

(b) If therapy is court-ordered and there is dispute regarding privacy, confidentiality and privilege, the CIT should seek clarification from the Court prior to commencing services. If a dispute arises as to the interpretation of the Court order after services have begun, the CIT should seek direction from the Court before releasing information.

7.5 Special issues in children's treatment

(a) A CIT should be familiar with general provisions governing confidentiality of children's treatment information in his/her jurisdiction, including:

(1) Who holds the child's privilege and how a child's privilege can be waived or asserted
(2) Under what circumstances a child or adolescent may have a role in this decision
(3) How the CIT should respond if he/she receives conflicting instructions from the parents
(4) How the CIT should respond if he/she believes that disclosure of treatment information poses a substantial risk of harm to the child

(b) At the outset of a child's treatment, the CIT should clarify the provisions of the order or therapy agreement regarding the child's treatment information. These issues include, but are not limited to:

(1) How information about a child's progress will be shared with parents
(2) Whether the consent of one or both parents will be required to release information about the child's progress
(3) The role that the child's thoughts and feelings will play in determining what information is shared, and how it is shared
(4) Circumstances in which the CIT may be required to release information to the parent or other professionals
(5) Circumstances that might require further discussion, clarification or modification of the order or agreement as the treatment progresses

(c) A CIT should prepare the child client for the release of treatment information, address the child's feelings about the issue, and assist the child in coping with any stressors that may result.

(d) The CIT should adapt explanations to the developmental and situational needs of each child.

(1) When working with a child client, the CIT should clarify the limits of confidentiality in developmentally appropriate language
(2) A CIT should not make blanket promises to a child that treatment information will be confidential

7.6 Considerations for therapists covered under the Health Insurance Portability and Accountability Act (HIPAA)

If the CIT is a HIPAA-covered entity, he/she must be aware of his/her obligations under the Act, and the how those obligations may change if the client or family

becomes involved with the Court. When requirements under HIPAA appear to be in conflict with other laws or Court orders, the CIT should obtain legal consultation.

7.7 Responding to requests for treatment information from third parties

(a) The CIT should request a copy of the release signed by the client, former client, parent, or other authorized person. The CIT should not communicate with a third party without an appropriate release or order of the Court authorizing disclosure.

(b) Prior to providing client information to a third party, the CIT should attempt to inform the client or former client about the request for release of information.

(c) The CIT should inform the client or former client of the nature of the information that may be released to a third party if the client waives the privilege. If appropriate, the CIT should also refer the client or former client to his/her attorney to assist the client in making this decision.

(d) A release does not supersede a Court order; therefore, prior to releasing information to a third party, a CIT should consult any agreement or Court order that governs the treatment.

7.8 Responding to a subpoena

(a) A CIT should be aware of differences between subpoenas and Court orders.

(b) A CIT who has received a subpoena should consider consulting an attorney familiar with both legal issues in the jurisdiction related to mental health law and the requirements of the Court in which the family is involved. Procedures, requirements, and the CIT's options will vary depending on the jurisdiction, whether the case is being heard in a family Court or juvenile dependency Court, and many other issues.

(c) A CIT should not automatically respond to a subpoena by disclosing written or oral information.

(d) A CIT should not ignore a subpoena.

(e) The CIT may wish to consider the additional guidance provided in Appendix A regarding specific steps that may be helpful in responding to a subpoena.

7.9 Responding to a Court order for release of treatment information

(a) If the CIT is ordered by the Court to release information, particularly over the

objection of one of the parties, the CIT should request a written order specifying the parameters of information to be released.

(b) If there are outstanding legal questions regarding what information can be released (such as whether the CIT can release information from other agencies or child protective services), the CIT may wish to obtain the assistance of an attorney who can bring these issues to attention of the Court and obtain clarification or direction.

7.10 Appealing a Court order

There are some circumstances in which a CIT may believe that disclosing information may violate ethical or professional practice guidelines applicable to mental health practice. In such a case, the CIT may wish to consult an attorney familiar with the laws of mental health privilege/confidentiality in that jurisdiction.

GUIDELINE 8: METHODS AND PROCEDURES

8.1 The CIT should adhere to the methods and procedures generally accepted in his/her particular discipline. In addition, the CIT should maintain methods and procedures consistent with being involved in situations, which may include litigation, testimony, and the reporting of various matters to Court, parties, or their attorneys.

8.2 Obtaining necessary information if the therapy is court-ordered

(a) The CIT should attempt to obtain all information necessary to conduct the court-ordered therapy and should discuss the goals of the court-ordered therapy with the client.

(b) As appropriate to the specific case, the CIT should request information that may be necessary for effective treatment. This may include permission to speak to a prior therapist or other involved professionals, copies of prior Court orders, therapy records, and reports from child custody evaluators, child protective services, or a guardian *ad litem.*

(c) The CIT should obtain necessary information, including copies of relevant Court orders, to confirm that his/her role is clearly defined and consistent with the therapeutic role and the CIT's expertise.

(d) If the CIT is unable to obtain information from the parties or counsel that is necessary to conduct treatment, the CIT may apply to the Court for further direction if the CIT has obtained appropriate releases. Application to the Court should be preceded by proper notice to the parties and counsel.

8.3 Therapeutic role and process

(a) The CIT has a responsibility to identify both the intended clients and any others intended to be the beneficiaries of the intervention.

(b) When the intended beneficiary of the intervention is an individual client, the primary focus of the therapist is the client's welfare and treatment is implemented for the benefit of the client. Therapists with different treatment orientations may identify different treatment goals, but all focus on improving client's functioning.

(c) In other cases, a relationship or family unit may be the identified client or may be the participants in counseling, but the goal may be to reduce conflict or promote behavior change for the benefit of the child (e.g., co-parenting or conjoint/reunification therapy).

(d) The CIT should clearly identify the goals, procedures and beneficiaries based on any relevant orders and in collaboration with the client(s) and other professionals as appropriate, and should clearly communicate this information to participants in the therapy.

8.4 The CIT should understand that the information provided by the client during the course of the treatment is based upon the client's experience and perspective, which may sometimes be distorted or lacking balance and comprehensiveness

(a) The CIT should strive to maintain professional objectivity, and to remain aware of the impact of the therapeutic alliance on the therapist's information and perspective.

(b) The CIT should actively consider alternative hypotheses regarding the information (i.e., data) he/she is receiving in the treatment.

(c) The CIT should strive to be aware of societal and personal biases and continuously monitor his/her actions for evidence of potential bias. Awareness of research and focus on the treatment data inform the CIT and help limit the potential for bias. The CIT should consider withdrawing from a case when he/she is unable to manage a known bias and/or is unable to maintain objectivity.

(d) The CIT should be aware that the treatment may be influenced by the client or family's involvement in legal processes, and that the legal process may be influenced by the actions of the therapist.

(e) The CIT must constantly guard against/protect his or her work from threats to professional objectivity and role boundaries.

8.5 Selecting appropriate treatment methods

(a) A CIT should not exceed the bounds of his/her professional competence in his/her diagnosis, treatment planning and treatment of clients.

(b) A CIT should use methods or interventions that are generally accepted within the professional communities and literature, and should apply methods or interventions appropriate to the situations and characteristics of court-involved families.

(c) A CIT should be able to justify and explain the choice of methods based upon the current state of professional knowledge and research.

(d) The CIT should select treatment methods or approaches that minimize the potential for biased or inappropriate interpretations of client's statements and behaviors or perceptions of others' behavior. This may include deliberate balance in asking questions, challenging assumptions, and supplementing behavioral observations with other methods of inquiry.

(e) A CIT should exercise caution in forming opinions or structuring therapy based on limited or one-sided information.

(f) A CIT should maintain current knowledge about the validity (or lack of validity) of using specific behaviors as a basis for diagnosis or treatment, and should employ treatment methods that allow the therapist to gather information from a variety of methods and observations.

8.6 Critical examination of information

(a) A CIT should critically examine information received from a client before formulating or offering a clinical opinion. This is especially important in light of the possibility that a therapeutic alliance may produce a bias toward the client.

(b) A CIT should recognize that loss of therapeutic objectivity may harm a child or family, whether or not the therapist reports or testifies about the therapy. Therapists should avoid inappropriate bias by actively considering, and exploring, rival hypotheses about a client's difficulties.

8.7 A CIT should consider the clinical implications of actions taken when the CIT is asked to release treatment information, and should endeavor to minimize risks in these areas

(a) The therapist should be aware that an adult client requesting the release of information may not fully attend to, or understand, the risks and benefits of such a decision. This may lead to distress in the client or damage to the therapeutic alliance, if the client is surprised by the therapist's information or opinion.

(b) The therapist should assist the client in understanding:

(1) The risks and benefits of releasing information
(2) The nature of the information in the client's records
(3) The CIT's obligation to provide complete answers when questioned under oath and to avoid misleading other professionals or the Court
(4) Other potential factors that may lead to distress in the client or damage to the therapeutic relationship due to the release of information

(c) When a child is involved in treatment and the CIT is asked to release treatment information, the CIT should consider and address issues to minimize disruption of treatment and avoid distress in the child. Issues to consider may include:

(1) Appreciation of the parent's right to information and any concerns that he or she may have about the child or the therapy
(2) Protection of the child's treatment progress and privacy
(3) Potential for disruption of the therapeutic relationship if the parent feels excluded or resorts to litigation in order to obtain information
(4) Possibilities for negotiating the parent's involvement and managing the sharing of information without violation of the child's privacy, wholesale release of treatment information, or litigation

(d) The CIT should consider and address the various clinical possibilities in children's expressed preferences about disclosure of information. The CIT should consider the potential implications of whatever action the CIT takes, and should utilize available therapeutic options for dealing with the child's information. Issues to consider and address may include:

(1) Treatment goals related to the children's resolving of issues with parents
(2) A child's realistic or unrealistic fears about the parent's response to the information
(3) The child's own emotional issues or difficulty in expressing feelings directly

(4) Whether the child will ultimately be empowered or protected by having the CIT share information on the child's behalf
(5) Whether the child needs protective measures to prevent harm resulting from the sharing of therapeutic information
(6) Whether information can be disclosed in a therapeutic rather than legal setting

(e) The CIT should prepare both adult and child clients for the sharing of information and endeavor to anticipate any problems the client may experience as a result.

8.8 A CIT should seek appropriate advice

When in doubt about an appropriate course of action, the CIT should consider seeking legal advice or professional consultation. Such advice may protect both the clients/participants in therapy and the CIT.

GUIDELINE 9: DOCUMENTATION

9.1 A CIT should create documentation so that the Court can understand the treatment process, progress and financial arrangements

9.2 A CIT should establish and maintain a system of record keeping that is consistent with applicable law, rules, and regulations and that safeguards applicable privacy, confidentiality, and legal privilege. A CIT should create and maintain records reasonably contemporaneously with the provision of services.

(a) In deciding what to include in the record, the CIT may determine what is necessary in order to:

(1) Provide competent care
(2) Assist collaborating professionals in delivery of care
(3) Provide documentation required for reimbursement or required administratively under contracts or laws
(4) Effectively document any decision making, especially in high-risk situations
(5) Allow the CIT to effectively answer a legal or regulatory complaint

(b) If a client, parent or third party requests limited record keeping as a condition of treatment the CIT should explain that record keeping must meet professional standards.

9.3 Records should be organized and sufficiently detailed

A CIT should maintain records that facilitate the provision of future services by the CIT and by other professionals, ensure accuracy of billing and payments, and ensure compliance with ethical requirements and laws. Records should be sufficiently detailed, legible and readily available for reproduction upon receipt of appropriate releases or Court orders.

9.4 Confidentiality and security of records

A CIT should make all reasonable efforts to maintain confidentiality in creating, storing, accessing, transferring and disposing of records under his/her control. A CIT should maintain active control of records, provide appropriate training to any support staff, and take reasonable care to prevent the loss or destruction of records.

9.5 Ethical and statutory requirements

(a) A CIT should be cognizant of and follow relevant ethical and statutory requirements regarding maintaining records.

9.6 Communicate and clarify recordkeeping with the client and/or parents

(a) When the client is a child, the CIT should request any orders establishing who has the authority to consent to release of records. A minor may have the legal prerogative to consent to treatment, but the parent may nevertheless seek access to the records. A CIT should verify parents' statements of having the sole authority to consent to or block release of records by requesting relevant documents.

(b) When the CIT has multiple clients, such as when a parent participates in therapy with the child, the CIT should clarify as part of the informed consent procedure how the records are kept and who can authorize their release.

(c) A CIT should clarify any costs associated with providing copies of records and follow relevant statutes regarding fee arrangements. A CIT should not refuse to release records needed for emergency treatment because a client has not paid for services.

(d) Even when clients are participating in therapy pursuant to a Court order, the CIT should clarify policies, procedures and fees associated with the release of records and confidentiality.

GUIDELINE 10: PROFESSIONAL COMMUNICATION

Communication from a CIT to another therapist, the client, parents, counsel, or the Court carries with it an obligation to ensure that the communication is authorized, clear, and accurate. A CIT should recognize the adversarial nature of the legal system and the potential impact of the therapist's observations and opinions.

10.1 Authorization to communicate

A CIT should take reasonable steps to ensure that he/she is authorized to communicate with a third party, as described in Guideline 7.

10.2 Accuracy in communication

(a) In communication with others, a CIT should take reasonable steps to ensure that he/she is accurate in communicating:

(1) The nature of the service provided
(2) His or her opinions on diagnosis, prognosis, and/or progress in treatment
(3) His or her opinions on appropriate actions that would support the therapy
(4) His or her understanding of the role the therapist has with the family and in the Court process
(5) Reports or observations of parents' or children's behavior

(b) The CIT should make reasonable efforts to ensure that information regarding his or her services, including treatment, reports and testimony is communicated in language that can be understood by consumers and minimizes potential for misuse of the therapist's information.

10.3 Communicating limits and distinctions

A CIT should communicate the bases and limitations of observations and opinions.

(a) In all communications, especially in reports or testimony, the CIT should distinguish between observations, verbatim statements, inferences derived from his or her sources of information and conclusions or assessments reached.

(b) A CIT should articulate the limits of any communications. A CIT should decline to communicate opinions, recommendations, or information requested:

(1) When there is insufficient data on which to form a reliable opinion
(2) When there is no authorization to do so
(3) When the opinion requested is inconsistent with the role of the CIT

(c) Where the information available to the CIT might support more than one therapeutic assessment or opinion, the CIT should present and acknowledge the alternate possibilities and any treatment data or research supporting them.

(d) When necessary and appropriate, a CIT should be prepared to explain the limits of the CIT's role and the reasons it is inappropriate to give testimony or opinions in violation of that role.

10.4 Appropriate parties to include in communication

A CIT should carefully consider who should be aware of and involved in each professional communication.

(a) The CIT should consider whether one or both counsel, a guardian *ad litem*, child's counsel, other CITs, or parenting coordinator should be included in the communication.

(b) The CIT should respond with caution if an adult client's attorney requests a treatment report, particularly if the request comes through the client. The CIT should discuss with the client the potential content and implications of such a report, as discussed in Guidelines 7 and 8. With an appropriate release, the CIT may also wish to consider consulting with the adult client's attorney to ensure that the attorney is aware of the potential content and implications of a report from the therapist.

(c) The CIT in a neutral role, such as that of child's therapist, co-parenting therapist or conjoint/reunification therapist, should avoid unilateral communication with either parent's attorney in order to avoid appearance of bias and to contain the potential for actual bias.

10.5 Testimony

(a) A CIT should recognize the limits of his/her knowledge, and the potential impact that testifying in Court may have on the client and on treatment. Prior to testifying, a CIT should thoroughly discuss these issues with adult clients, and should engage in age-appropriate preparation of child clients.

(b) A CIT should comply with any limits on the scope of his/her testimony, which have been specified by a judicial officer in conjunction with any applicable ethical code.

(c) A CIT should anticipate that clients, attorneys, and the Court may ask the CIT to testify beyond the limits of his or her knowledge and role. The CIT should respectfully decline to provide information or opinions that exceed the treatment role or the CIT's knowledge base.

(d) A CIT should seek to clarify any conflicts between the testimony requested by the Court or counsel and any limitations imposed by professional ethics codes or licensing regulations.

(e) When the CIT is designated as an Expert Witness by the Court he or she may offer relevant clinical opinions within the role of the treating expert.

(1) The CIT may offer opinions on issues such as diagnosis, changes or behaviors observed in treatment, treatment plan, prognosis, coping and developmental abilities, conditions necessary for effective treatment, etc.
(2) The CIT should not render opinions on psycho-legal issues (e.g., parental capacity, child custody, validity of an abuse allegation, joint or sole custody), as these are beyond the scope of the treatment role and properly the province of other professionals and the Court

APPENDIX A

RESPONDING TO A SUBPOENA

This material is intended to supplement the information in Guidelines 7 and 8.7 regarding privilege and confidentiality issues, and the clinical management of requests for treatment records or information.

1. A subpoena is not a Court order. It is a formal request from an attorney to summon a witness or require a witness to bring documents to a hearing. The hearing might be a deposition (oral testimony taken under oath in preparation for a formal trial or to preserve the evidence) or a trial itself.

2. A CIT should never ignore a subpoena.

3. A CIT should not assume that a subpoena requires him or her to automatically disclose all requested information

4. Some jurisdictions have detailed statutes regarding psychotherapist privilege. These may include specific statutorily-mandated steps the CIT can take in response to receipt of a subpoena. In other jurisdictions, a CIT may want to obtain legal advice from an attorney familiar with (1) the privacy law in that jurisdiction; (2) the requirements specific to family court cases or the laws governing the CIT's role; and (3) the ethical obligations of mental health professionals. It is important for each CIT to know the state of the law in his or her jurisdiction on this issue and for the CIT to provide his/her counsel with any specific orders governing the CIT's role in the particular case.

5. The requirements for responding to a subpoena may be different in a juvenile or dependency court, a family court, a general civil court and a criminal court. When obtaining legal counsel with regard to a subpoena, the CIT should know which type of court is the setting for the case that generated the subpoena and should provide legal counsel with all relevant orders and documents.

6. If a CIT receives a subpoena regarding an adult client's treatment, he or she should make and document best efforts to notify the client or former client that the subpoena was served. The CIT should let the client know the scope of the information sought in the subpoena and that the client has a right to consult counsel to determine how best to respond to the subpoena.

7. If the subpoena was sent by the client's attorney, the CIT may, with the written consent of the client, cooperate with the attorney.

8. If the subpoena was sent by opposing counsel, the CIT may, with the written consent of the client, cooperate with the client's attorney to design a strategy for response to the subpoena.

9. In working with the client's attorney, it is important for the CIT to learn what the attorney hopes to gain from the CIT's involvement in (or exclusion from) the case, the issues being litigated, and the information and/or opinions that the lawyer will ask the CIT to reveal. The CIT should also attempt to learn what the opposing side is trying to achieve and whether and in what way the opposing lawyer may attempt to discredit the CIT's information and/or opinions.

10. Upon receipt of the subpoena, the CIT should carefully review his or her own records regarding the client and be prepared to discuss with the client and his or her attorney the following:

    A. Whether the record contains outdated material;
    B. Whether the record contains highly personal material;
    C. Whether the record contains information that could help the client achieve the goals described by the client's attorney;
    D. Whether the record contains information that could harm the client's goals.

11. If the subpoena was sent by the opposing attorney, the CIT should discuss with the client's attorney whether or not it would be useful to attempt to negotiate with opposing attorney to limit the scope of the subpoena, e.g., to redact outdated material, the names of third parties not important to the litigation or highly personal information.

12. The CIT should discuss with the client's attorney whether or not it would be wise to bring a Motion to Quash the subpoena, i.e., a request of the Court that the CIT be relieved of the obligation to provide testimony or produce records. The Motion to Quash must be grounded in some legally-cognizable rationale. For example, the material known to the CIT may not be relevant to the litigation. Or the opposition might be able to obtain the information known by the CIT from other sources, which would be less invasive to the client than obtaining information from the CIT. Or in some jurisdictions it will be possible to argue that, even though the CIT has information bearing on the case, it is more important that the client's privacy be maintained than that the information be disclosed.

13. If a child is the CIT's client and the child's records are subpoenaed, the CIT should consider whether or not the potential consequences to the child warrant opposing release of the information, requesting that an independent advocate be appointed, or warning the involved parties about risks to the child from release of the information. The CIT should be familiar with the procedures in his or her jurisdiction that are used to protect or consider the child's treatment information. In most jurisdictions, under ordinary circumstances, the parents or the person with legal custody of the child or the legal guardian has the power to determine whether or not to allow a child's private information to be released. However, if the parents are themselves in conflict in the litigation, the jurisdiction may have a special process for determining the child's privacy rights (as the parents are in a conflict of interest position about the child's privacy rights). Some jurisdictions will have a procedure by which a specially appointed person will decide,

after learning more about the litigation and the effects on the child, whether to waive or to assert the child's privilege. In some jurisdictions the decision of that appointee is decisive; in other jurisdictions, the person's decision is a recommendation to the Court, which has the final say.

14. If the CIT is asked to give information or an opinion about the effect on the child client of release of treatment information, the CIT should be prepared to explain the potential impact on the child of releasing the information and, conversely, the potential impact of withholding the information and the risks and benefits of each. Relevant factors might include the child's wishes, the impact of the decision on the child's ability to trust therapy and the CIT following a disclosure, the child's needs or ability to have his or her voice heard in the litigation, and whether or not there are other, less intrusive sources for obtaining the information.

15. The CIT should be aware that ultimate decisions regarding release of treatment information may not be the province of the therapist. Properly informed adults, and their attorneys, may have the right to control their treatment information. Those charged with protecting the child, such a minor's counsel, Guardian Ad Litem or the Court, may need to weigh and determine the best means of protecting the child's interests.

For supplemental information, please see the following documents:

Sample client-therapist contract:

http://www.afccnet.org/Portals/0/PublicDocuments/guidelines/Client-therapistcontract.pdf

Sample order for counseling:

http://www.afccnet.org/Portals/0/PublicDocuments/guidelines/OrderforCounseling.pdf

Sample stipulation and order for counseling:

http://www.afccnet.org/Portals/0/PublicDocuments/guidelines/StipulationandorderforCounseling.pdf

Suggested references:

http://www.afccnet.org/Portals/0/PublicDocuments/guidelines/Suggestedreferences.pdf

STUDENT NOTES

HIGH-CONFLICT DIVORCE: A FORM OF CHILD NEGLECT

Alexa N. Joyce

In high-conflict divorce cases, the emotional toll on the family unit is unquestionably destructive. While the physical and mental health of the children should be the primary focus, the emotional turmoil of a high-conflict divorce often moves the focus away from the children as parents struggle emotionally and financially. Although the best interests of the children are always in the judicial purview, the repeated, lengthy, and hostile litigation process often associated with high-conflict dissolution has lasting effects on the physical and mental health of children, similar to those associated with physical abuse and neglect. Child Protective Services (CPS) must step in and protect the emotional well-being of children during high-conflict divorce cases.

Key Points for the Family Law Community:

- High-conflict divorce is detrimental to the entire family unit and often causes emotional and psychological harm to the children.
- Children entrenched in their parents' high-conflict divorce experience emotional neglect.
- Emotional neglect is an under-recognized form of child neglect that warrants state intervention through Child Protective Services.
- Emotional neglect is underreported and often unrecognizable to the untrained eye.
- Child Protective Services must be responsible for investigating possible emotional neglect in high-conflict divorce cases and connecting families with appropriate therapeutic interventions.
- An attorney for the child must be appointed where Child Protective Services is forced to petition the court for compliance with therapeutic intervention or services.

Keywords: *Child Abuse; Child Neglect; Child Protective Services; Divorce; Emotional Harm; Emotional Neglect; High Conflict; Mental Health; Parental Conflict; Social Work Perspective; and Therapeutic Intervention.*

I. INTRODUCTION

Everyone in the courtroom was crying—everyone but the parents of the two young children. The case began as a typical divorce. After three years of expensive, lengthy, and draining litigation, the case was finally set for trial. What made this case unique, however, was the presence of the New Jersey Division of Child Protection and Permanency (DCPP)[1] and a law guardian[2] appointed to represent the two minor children. A DCPP case was opened when the parents began making baseless allegations of sexual abuse and child neglect. Although the allegations were unfounded, the case remained open because the father continued to make accusations of physical abuse and neglect against the mother on a biweekly basis. The caseworker was the only adult willing to supervise and facilitate visitation between the brothers. He understood how precious their visits were together and the importance of sibling bonding to the emotional and developmental health of the boys. Additionally, the court-appointed law guardian was not comfortable being removed from the case and leaving the two minor children with no voice or representation.

The mother in this case remained in the marital home with the younger child, Michael, age six.[3] The father, upon being "evicted" from the mother's rental home, decided to move to the farthest

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FAMILY COURT REVIEW, Vol. 54 No. 4, October 2016 642–656

corner of New Jersey, almost three hours away. The father took the older son, Sean, age ten, with him to his new home.[4] The parents pitted the child in their custody against the noncustodial parent. On the first day of trial, Michael and Sean were both individually interviewed by the judge in chambers while the rest of the courtroom listened to their heartbreaking testimony. It was clear to everyone in the courtroom that the older child was brainwashed by his father to believe the most terrible and disgusting, albeit baseless, facts about his mother. On the other hand, the younger son was completely terrified and wary of his father. What the two brothers truly wanted was to be together.

During his interview, Michael began to cry numerous times. Through his tears, Michael raised his voice and began shouting: "No, my parents can't agree about anything. NOTHING. I don't get it. I don't get why. But I don't care. I just want to be with my brother. I don't care if we have to be with my mom or my dad. I don't care about seeing either of them, I just want to be with my brother." In that moment, it was clear why the DCPP case was never closed. The children needed protection, a voice, representation, and supervision of their emotional and physical health.

Upon observation of Michael and Sean, it was clear that they not only loved and cherished their sibling relationship, but they also enjoyed more trust and respect in their relationships with their caseworker and attorney than with their own parents. While their parents continued to bicker during the lunch break, the caseworker volunteered to take the children to lunch and to the park to facilitate visitation. The parents could not agree on anything regarding visitation for the children. The caseworker and law guardian were the only two adults willing to stand up for the children and to help them foster their sibling relationship. At the end of the second day of trial, the law guardian insisted on sibling visitation[5] during the pendency of the trial. Both attorneys for the parents immediately stood up to contest this request on behalf of their clients. It was clear the parents no longer had the ability to recognize the best interests of their children as the highest priority in this case. Their priority was winning and making sure that the other side suffered.

"High-conflict divorce" will be used throughout this Note to refer to cases associated with extreme lack of trust between parties, elevated levels of anger, and willingness to engage in repetitive litigation[6] as well as to parental relationships marked by fear, projection of blame, refusal to cooperate or communicate, allegations of abuse, and sabotage of parent–child relationships.[7] Only about one tenth of divorcing couples experience repeated litigation and proceed to trial before coming to a final stipulation.[8] This repeated litigation, overt hostility, anger, and tension carries over into the daily lives of children who are victimized by their parents' high-conflict divorce.[9]

The developmental, emotional, and physical health of children involved in these divorces are dramatically affected.[10] The inability of the parties to settle disputes creates high levels of anxiety and defensiveness within the family unit. Additionally, high-conflict divorce decreases parenting competence and reduces the prioritization of the best interests of the children.[11] For children involved in high-conflict divorce, coping strategies, adjustment, academic achievement, self-esteem, psychological distress, depression, delinquency, substance abuse, sexual precocity, and suicidal behaviors may color their future long after dissolution of their parents' marriage.[12] The unintended victims of high-conflict divorce must be adequately monitored.

Parents involved in high-conflict divorce are often not emotionally stable enough to ensure the best interests of the children are protected throughout the litigation process.[13] They often evaluate their decisions from a place of anger, jealousy, and self-centeredness. While some jurisdictions do provide mechanisms to protect the child in certain situations, including the appointment of a guardian ad litem[14] or an attorney for the child,[15] the rights and needs of children must be statutorily protected nationwide.[16] As previously mentioned, high-conflict divorces represent a relatively small percentage of all marital dissolutions in the United States.[17] However, in the last two decades, nearly two million children were caught in the crossfire of these contentious dissolutions.[18] As a matter of public policy, there is a need for a more regulated and consistent protection of these children.[19]

This Note proposes the implementation of a national, statutory two-pronged approach to the dissolution of marriage in high-conflict cases. The statutory provision will require: (1) referrals to CPS by the family or matrimonial court judge presiding over any case deemed to be high conflict and/or involved

in continuous litigation for more than eighteen months and (2) the appointment of an attorney for the child, upon a finding of emotional neglect and noncompliance with recommended CPS services.

In Part II, this Note will discuss the effects that high-conflict divorce has on children and parents, both during and after the dissolution process. Part III will discuss the effects of physical abuse and neglect on children as well as the traditional role of CPS. Thereafter, this section will describe the reluctance of CPS to provide services for emotionally neglected children and compare the effects of various types of abuse and neglect on children. Part III will discuss the need for the emotional neglect of children to be more thoroughly protected by CPS as it relates to high-conflict divorce. Part IV will discuss how CPS can ensure the emotional needs of children are addressed during high-conflict dissolution. This section will argue for a uniform national statute mandating CPS investigations and the appointment of an attorney for the child where there is a substantiated finding of emotional neglect. Part V will address the risks and benefits of creating a separate statute for the welfare of children involved in high-conflict divorce cases as it relates to children, families, and social policy. Part VI will reiterate the importance of protecting the emotional well-being of children involved in high-conflict dissolution cases through the implementation of a uniform statute.

II. THE EFFECTS OF HIGH-CONFLICT DIVORCE ON CHILDREN AND FAMILIES

A. WHAT IS A HIGH-CONFLICT DIVORCE?

High-conflict divorce is illustrated by a consistent desire to litigate, extreme hostility, and lack of trust between parties that may emanate from dysfunctional marital relationships, mental health disorders, criminal backgrounds, substance abuse, and/or allegations of domestic violence or child abuse.[20] Characteristics of high-conflict divorce include: repetitive disputes over parenting practices, physical threats, and actual violence.[21] Allegations of adultery or instances where one partner abandons the marriage while the other partner is still in love often lead to elevated levels of hostility, anger, and distrust.[22] The dynamics of the relationship, both pre- and postseparation as well as the personality traits and mental health concerns of the couple may thrust a family into a heated, hostile, and strongly contentious divorce.

Some commentators argue that the adversarial system of a matrimonial proceeding exacerbates conflict in contentious divorce proceedings.[23] While partners in a failing relationship are experiencing hostility, their attorneys who zealously represent their clients may only worsen the problem.[24] The desire of both sides to "win" the divorce can perpetuate conflict, litigation, and feelings of hostility.[25] Linda D. Elrod, a distinguished family law professor at Washburn University School of Law, argues that "the win/lose framework [of litigation] encourages parents to find fault with each other rather than to cooperate."[26] In an attempt to enhance their client's position, attorneys often make "extreme demands to increase the bargaining advantage [which] only escalate[s] conflict."[27] Repeated litigation drains both parties of financial and emotional resources.[28] This contributes to increased levels of stress and anxiety that often present as anger, aggression, and hatred.

B. MAKING THE DECISION TO END A MARRIAGE CONSIDERING THE BEST INTERESTS OF THE CHILDREN

The interpersonal and interfamilial dysfunction that often leads to high-conflict divorce disturbs the entire familial unit.[29] These disruptions often lead to behavioral and emotional issues for children both during and after the dissolution.[30] Regardless of whether a divorce is considered high conflict, it is nonetheless a traumatic experience for children as family finances diminish, one or both parents leave the marital home, and parents become less likely to "meaningfully and constructively" attend to their children's needs.[31]

Commentators and social scientists have long debated whether or not it is more appropriate for parents to stay together for the sake of the children or to end the marriage.[32] While conservative viewpoints endorse the notion that divorce is always bad for children, social science research indicates that "children who are exposed to serious conflict in their parents' marriage are better off when conflict is reduced by divorce."[33] However, high-conflict marriages are often precursors to high-conflict divorces. The marital conflict generally carries over into the divorce and accentuates the effects of the dysfunctional parental relationship on the emotional well-being of the children.[34]

C. THE EMOTIONAL EFFECTS OF HIGH-CONFLICT PARENTAL RELATIONSHIPS ON CHILDREN

While acknowledging that ending a high-conflict marriage is generally beneficial to children, social science further suggests that high levels of parental conflict during the marriage often carry into the dissolution process and continue to harm the emotional well-being of children.[35] Symptoms such as conduct disorders, antisocial behaviors, difficulty with peers and authority figures, depression, and academic problems are found more frequently in children from high-conflict marriages as opposed to children from low-conflict marriages.[36] In general, children of divorce are more aggressive and antisocial.[37] Children who experience high-conflict marriage and divorce are more prone to depression and other mental health issues as young adults.[38] The more frequent and continuous the parental conflict, the more likely it is to have a negative impact on the children.[39] Parental conflict that is centered on the children, such as custody, parenting time, visitation, or support, is most troublesome and causes children to "express more self-blame, shame, and fear of being drawn into the conflict."[40]

D. HOW HIGH-CONFLICT DIVORCE AFFECTS CHILDREN SOCIALLY

Parents are the primary exemplars for children on how to handle conflict, compromise, and resolution. Children often mirror their parents' behavior, viewing them as role models, mentors, and teachers of life skills, coping mechanisms, and communication techniques.[41] Because parents involved in high-conflict marriages and divorce are commonly lacking in these skills, they frequently pass these deficiencies on to their children.[42] Because these skills are often inadequately modeled in families with high levels of parental conflict, children often struggle with social interaction.[43] They become overly angry, impulsive, or violent whenever they experience conflict.[44] Healthy modes of expression are generally absent in high-conflict relationships, which causes children to exhibit frequent and extreme anxiety based on their inability to communicate.[45]

Additionally, parents involved in high-conflict marriage and divorce are more likely to use drugs or alcohol.[46] Consequently, their children are more prone to alcohol, cigarette, and marijuana experimentation than children from intact, low-conflict families.[47] Children whose parents divorce are more likely to experience unwed pregnancies, earlier marriages, weaker marital relationships, increased incidences of divorce, and lower socioeconomic status.[48]

E. THE EFFECTS OF HIGH-CONFLICT DIVORCE ON PARENT–CHILD RELATIONSHIPS

The presence of high conflict during marriage and throughout the dissolution process "undermines the quality of parenting" and parent–child relationships.[49] Conflicting spouses often undermine consistent parenting techniques. Fathers tend to shrink away from their role as disciplinarians or mentors whether it be willfully or by pressure from the mother.[50] This may decrease the quality of parent–child interactions and cause children to feel rejected.[51] The disruption of parenting and the use of contradicting parenting methods often lead to significant gaps in supervision.[52] Children in search of stability and recognition are therefore more likely to experiment with substance use as they migrate

toward friends.[53] Additionally, due to lack of supervision, children of divorce often experience lower levels of academic achievement.[54]

Parents in high-conflict marriages are often depressed.[55] This has a negative impact on the children as they model their parents' behavior.[56] Social science suggests that adjustment of the custodial parent postdivorce is the "best predictor of child adjustment."[57] Continued conflict between parents and parental emotional distress make it difficult for the child to adjust to the divorce, particularly when the parent–child relationship is strained.[58] Children often exhibit less affection and contact and are less likely to care for their parents as they age.[59]

F. HOW THE FINANCIAL CONSEQUENCES OF HIGH-CONFLICT DIVORCE AFFECT CHILDREN

Throughout the divorce process, a substantial amount of family resources are used for legal fees, child care, and reorganization of assets.[60] Often families must adjust to supporting two households instead of one.[61] The entire family suffers from a "substantial decline in standard of living," causing the children to experience a sense of financial insecurity.[62] As described by Joan B. Kelly, a psychologist dedicated to researching the impact of divorce on families, "it is estimated the economic problems of divorced households account for as much as half of the adjustment problems seen in [. . .] children."[63] The primary lingering financial effect for children from high-conflict divorce is less educational success and career options based on lack of adequate financial support.[64]

III. STATE INTERVENTION IN CHILD ABUSE AND NEGLECT CASES

A. THE EMOTIONAL EFFECTS OF PHYSICAL ABUSE AND NEGLECT ON CHILDREN

Physical child abuse and neglect are major public health issues.[65] Physically abused children often exhibit: poor ego development, anxiety, social detachment, aggression, and self-destructive behavior.[66] Abuse and neglect often damage child development and intensify antisocial behaviors.[67] Children often have intellectual deficits, underachieve academically, and have high rates of maladjustment.[68] The likelihood of physical abuse and neglect and the perpetuation of its harmful effects on children are often aggravated when parents are struggling with their own mental health or substance abuse issues or when the home environment is unstable.[69] Abused and neglected children typically do not have consistent or affectionate parental guidance, which causes lasting developmental, emotional, and social impediments.[70]

Physical abuse and neglect are easily identifiable by social workers, teachers, and lay people.[71] According to social work writer, Kieran O'Hagan, most agencies that deal with child abuse and neglect are "preoccupied with physical or sexual abuse to the exclusion of any other potential area of abuse."[72] Physical abuse and neglect is often easiest to prove because it is readily identifiable to the untrained eye.[73] Anyone can identify with ease a child who has bruises or who does not have appropriate clothing.[74] Therefore the primary focus of state intervention through its *parens patriae* power is the physical abuse and neglect of children.[75]

B. THE DEVELOPMENT OF STATE INTERVENTION IN PHYSICAL ABUSE AND NEGLECT CASES

In the 1960s and 1970s, states began to recognize the need for specialized investigations of allegations of child abuse and neglect.[76] By 1974, the Child Abuse Protection and Treatment Act (CAPTA) facilitated the rapid creation of CPS agencies nationwide.[77] In accordance with mandatory reporting statutes, most CPS agencies created "highly publicized 'hot lines'" to allow the public to make anonymous reports of abuse.[78] It is arguable that the majority of reports made to CPS would not be made

without mandatory reporting laws and the development of media campaigns calling attention to the importance of protecting children from physical abuse and neglect.[79]

Generally, when an individual calls the hotline, they speak with a trained caseworker from CPS.[80] If the caseworker finds that a child may be at risk, an investigator from CPS will investigate the allegations, generally within twenty-four hours of the report being made.[81] Although the process for investigations and the implementation of services varies by state, all CPS agencies perform similar functions:[82] investigate families and determine the best way to remedy their situation.[83] Working from a social work perspective, CPS helps families decide if mental health or social service programs would be beneficial in remedying substantiated cases of abuse or neglect.[84] Often parents are willing to work with CPS to remedy abuse and neglect, and court intervention is not necessary.[85] Ordinarily, the goal for most CPS agencies is to work toward resolving concerns using therapeutic intervention.[86] However, family court intervention is necessary when CPS recommends placing a child outside of the home or when a family is not cooperative.[87] Criminal prosecution is less common and depends on the severity and type of abuse or neglect.[88]

C. WHAT IS EMOTIONAL NEGLECT?

Emotional neglect is a form of neglect that lawyers, judges, and parents may not easily understand or acknowledge.[89] It is a common, yet underdocumented, form of neglect that is hard to identify, define, and prove.[90] Although emotional neglect often does not encompass any clear intent to cause harm to the child, it inevitably can cause physical, social, educational, and emotional impediments.[91] Emotional neglect is harmful to child development and its consequences often carry into adult life.[92] Emotional neglect has strong correlations with negative long-term psychological functioning, including "internalizing and externalizing behaviors, social impairment, low self-esteem, suicidal behavior, psychiatric diagnoses, and hospitalizations."[93]

Parental unavailability, unresponsiveness, and preoccupation with the parent's own personal mental health and substance use issues often lead to emotional neglect.[94] Where parents are unable to respond to the emotional needs of their children, children often feel responsible for filling the psychological voids created by their parents.[95] Continuous hostility, denigration, rejection, and/or exposure to traumatic life events often lead to emotional neglect.[96]

D. EMOTIONAL EFFECTS OF HIGH-CONFLICT DIVORCE VERSUS PHYSICAL ABUSE AND NEGLECT

High-conflict divorce often involves the emotional neglect of children. Witnessing interparental conflict is one of the most stressful life events for children.[97] Emotional neglect results when parents are preoccupied with their own financial, social, and emotional concerns.[98] High-conflict divorce is generally a traumatic life experience for a child that unquestionably exposes them to various risk factors of emotional neglect.[99] During divorce, children experience and must cope with drastic shifts in their living and financial situations. Their parents are often unavailable to provide emotional support during these stressful times, because they are engrossed with their own anxieties and/or lack productive coping mechanisms.[100]

Children of high-conflict divorce experience emotional effects similar to those experienced by children who are victimized by physical abuse and/or neglect.[101] Children who witness high-conflict parental dissolution similarly exhibit depression, antisocial behaviors, conduct disorders, low academic achievement, and problems with authority.[102] High-conflict divorce is a form of emotional neglect, and children should be afforded the same state protection provided to physically abused and neglected children.

E. WHY CPS INTERVENTION FOR EMOTIONAL NEGLECT IS RARE, IF NOT NONEXISTENT

Even though CPS workers are under a legal, moral, and professional obligation to recognize and understand emotional and psychological abuse, agencies often require workers to identify evidence of physical abuse or neglect before they can open cases.[103] Emotional neglect cases are rarely opened by CPS and are even less likely to be brought to the attention of a family court judge.[104] In general, the emotional health of children is only examined in conjunction with physical abuse and neglect, or intervening to ensure the mental health of a child is protected as it pertains to the effects of physical abuse.[105]

Emotional neglect ought to warrant the same state intervention as physical abuse and neglect. The state has parens patriae power to protect children from abuse and neglect at the hands of parents, guardians, or primary caregivers.[106] Read plainly, this power should require the state to intervene to protect children from emotional harm unrelated to physical abuse or neglect.[107] Courts pay very little attention to the stand-alone emotional needs of children, because the term "emotional health" is less understood by people outside of the mental health field.[108]

Therefore, CPS caseworkers must be responsible for identifying the emotional neglect of children.[109] Children are often at risk for emotional neglect when parents are preoccupied with their own mental health, substance use, or financial difficulties.[110] Often, parents are unable to identify emotional or psychological concerns and/or are unaware of interventions that are available.[111] Emotional neglect must be reported to CPS by schools, doctors, and social services.[112] It is necessary for trained caseworkers, operating from a social work perspective, to investigate, identify, and provide services to remedy potential emotional neglect.[113]

IV. MANDATORY STATE INTERVENTION IN HIGH-CONFLICT DIVORCE

A. THE SOLUTION

Investigations by CPS should be statutorily mandated in high-conflict divorce cases. The number of divorce cases characterized as high conflict is relatively low.[114] As conflict and litigation continues, even after a judgment of divorce is entered, parents in high-conflict cases deplete financial resources and continue to expose children to trauma.[115] Although high-conflict divorce cases are a breeding ground for the emotional neglect of children, these cases are generally not pursued by CPS and are rarely brought to the attention of the family court.[116]

While it is undisputed that the states' parens patriae power is intended to protect children from abuse and neglect, there is currently no universal definition.[117] The Child Abuse Prevention and Treatment Act includes in its definition of abuse and neglect, "any recent act or failure to act on the part of a parent or caretaker which results in [. . .] serious [. . .] emotional harm."[118] State intervention for emotional neglect should be required in accordance with the parens patriae power.

In high-conflict divorce cases, parents are often unable to recognize the unintended infliction of emotional neglect on their children, as they are preoccupied with their own issues and repeated litigation.[119] Because some matrimonial judges and lawyers may be ill equipped to acknowledge the stand-alone effects of the emotional neglect of children, it is imperative that CPS intervene on behalf of the children to connect the family with appropriate therapeutic interventions.[120] A federal statute should be adopted mandating state CPS agencies to investigate the emotional well-being of children where parents have been involved in high-conflict litigation for more than eighteen months. Upon a finding of emotional neglect, CPS shall intervene to implement appropriate services or therapeutic intervention.

B. HOW EMOTIONAL NEGLECT SHOULD BE UNIVERSALLY DEFINED

An emotionally neglected child is one whose parent, guardian, or primary caregiver either intentionally or unintentionally exposes the child to repeated traumatic situations, including but not

limited to extreme interparental conflict, emotional unavailability, or constant personal preoccupation.[121] In order to appropriately deem a child emotionally neglected, it is necessary for a mental health professional to evaluate the child.[122] Any child experiencing interparental conflict, including high-conflict divorce, for more than eighteen months is at risk for emotional neglect.[123] The presence of repeated, contentious, and lengthy litigation as well as intense levels of mistrust and hatred between parties is often unobservable to the untrained eye.[124] Therefore, after the eighteenth month of litigation, cases involving children should automatically be referred to CPS for a trained caseworker to investigate the need for services.

C. THE PROCEDURE FOR SUGGESTED STATE INTERVENTION

Similar to screening protocols for traditional physical abuse and neglect cases, trained caseworkers shall be responsible for meeting with children to determine whether they are at a heightened risk for emotional neglect.[125] Although unrecognizable to the untrained eye, emotional neglect is relatively easy for trained mental health professionals to identify.[126] A caseworker will determine the presence and severity of a number of factors to decide whether intervention and referral to mental health services is necessary by meeting with the children, parents, and other interested parties. The caseworker will examine: parental preoccupation with personal stressors[127]; the presence of conduct disorders, antisocial behaviors, difficulty with peers/authority figures, depression, academic problems, or anxieties in children[128]; whether parental conflict is predominantly centered around child-rearing issues[129]; and the level of parent–child affection and contact.[130] Caseworkers will use their professional judgment to determine whether a CPS case should be opened to provide services on the basis of emotional neglect.[131]

If a case is opened, CPS will work with the family to create an intervention plan to protect the emotional well-being of the children. The caseworker will connect the family with appropriate therapeutic services.[132] It is not likely a criminal or civil case will be opened against parents, except under extreme circumstances or where parents refuse to comply with the plan for therapeutic intervention.[133] Typically, parents will be willing to comply as they may have simply been unaware that their children's emotional needs were not being met.[134] If parents are noncompliant, CPS may petition the judge presiding over the matrimonial matter to order compliance.[135] If the court becomes involved, an attorney for the child shall be appointed.[136]

A pilot program should be implemented in each state prior to the adoption of a statute. It is unquestionable that high-conflict divorce generally leads to the emotional neglect of children based on the very nature of elevated levels of familial conflict and stress. Children involved in high-conflict divorce, nationwide, who are the victims of emotional neglect, must be afforded the same protection of state intervention as are children in physical abuse and neglect cases who suffer comparable emotional hardships.[137]

V. COSTS AND BENEFITS

A. HOW THE SOLUTION WILL PROTECT CHILDREN FROM A SOCIAL WORK PERSPECTIVE

The vast majority of emotional neglect cases are currently being ignored.[138] Although domestic violence and substance use certainly may be present during high-conflict dissolution, families do not generally exhibit any overt characteristics of physical abuse or neglect.[139] Instead, continuous litigation and conflicting parenting practices color the family dynamic, leaving children without proper emotional guidance.[140] High-conflict divorce is one of the strongest predictors of poor outcomes for children.[141] Mandatory intervention by CPS is only suggested in high-conflict cases, a disproportionately small number of divorce cases nationwide.[142] Most children and families are able to endure dissolution of a marriage without any long-lasting emotional harm, however, children

cannot survive divorce unharmed where there is "prolonged, chronic, hostility between parents."[143] In high-conflict situations, children are often left to "pay the price of their parents' stormy court battles."[144] It is nearly impossible for children involved in high-conflict divorce to escape from emotional harm.[145] CPS must be involved to ensure children receive adequate services, at least during the pendency of litigation.

Intervention would ensure parents are educated about and aware of the emotional harm they are inflicting on their children. While this may not expedite a faster resolution, parents may at least be made aware of the harm their contentious litigation is imposing on their children. CPS can work with a family to create an intervention plan to help them locate financial and therapeutic resources. Assuming the parents are receptive, no further action would be required either through the court or law enforcement absent a finding of physical abuse or neglect.

B. DISTINGUISHING EMOTIONAL NEGLECT FROM ABUSE AND THE EFFECTS OF THE SOLUTION ON PARENTS

High-conflict divorce or emotional neglect must be distinguished from abuse. Under the recommended statute, parents will not be held criminally liable for emotional neglect. Currently, there appears to be a recurrent disconnect within CPS agencies, as workers attempt to protect children without labeling or blaming caregivers.[146] This has led to inadequate protection for children against emotional neglect.[147] The number of children who are emotionally neglected and would benefit from the support and protection of CPS is seriously underestimated.[148] State intervention is necessary, but must be structured so as to protect the family unit from unnecessary social or financial destruction. The term neglect connotes the presence of poverty or interfamilial issues as opposed to serious criminal behavior indicated by the term abuse.[149] The argument that CPS should intervene is based on the inability of laypersons to identify emotional harm, parental fixation with personal turmoil, and the need to protect children, not the criminal fault of the parents.[150]

Only where a family is noncompliant will court intervention be necessary. The judge presiding over the matrimonial matter should be responsible for implementing intervention plans upon noncompliance. Unless, upon investigation, the caseworker finds physical abuse and/or neglect, the standards, protocol, and consequences for a finding of emotional neglect in a high-conflict divorce case will be much less severe and only operate to call attention to issues and employ therapeutic intervention. Where CPS petitions the court for implementation of a service plan, an attorney for the child must be appointed to ensure the wishes of the child are reflected on the record.[151]

C. WHAT ARE THE COSTS FOR CPS AND THE COURT SYSTEM?

Establishing a new statutorily recognized form of neglect for already overworked CPS caseworkers to investigate may seem unnecessary, expensive, counterproductive, and wasteful. But only about ten percent of divorcing couples are considered high conflict and intervention would only be mandatory after eighteen months of litigation.[152] A number of these cases may already be open with CPS as some high-conflict divorce cases are colored with domestic violence, substance abuse, and/or physical child abuse and neglect.[153] It is unfathomable to ignore the thousands of children who are currently disregarded by CPS simply because there is no substantiated claim of physical abuse or neglect. These children suffer through years of emotional neglect as their parents viciously fight to dissolve their marriage.[154]

It is estimated that a single divorce case costs the government $30,000.[155] The annual average cost of divorce for taxpayers is over $30 billion.[156] CPS involvement may entice parents to realize the detrimental effects of continued litigation and come to a resolution, saving not only the parties, but also the taxpayers and court system millions of dollars.[157] By addressing the emotional needs of the family, most importantly the children, CPS involvement may lessen the likelihood of juvenile

delinquency and societal issues faced by children of high-conflict divorce whose mental health needs are not adequately addressed.

VI. CONCLUSION

Sean and Michael were afforded the opportunity to have a caseworker provide services throughout their parents' divorce process.[158] It was clear that the brothers were emotionally neglected by their parents. Their parents had entirely lost their ability to recognize the harm their divorce was causing the children. If there had been a statutory protocol requiring CPS to investigate and intervene in cases involving the emotional neglect of children in high-conflict cases, these brothers would have been provided the appropriate services without exposure to baseless, shameful, and harmful allegations of sexual and physical abuse in addition to their parents' long, drawn-out, and contentious divorce. Mandating CPS involvement in high-conflict divorce cases can safeguard the emotional health of children and families while ensuring that the appropriate services are accessible.

NOTES

1. The New Jersey Division of Child Protection and Permanency is the Child Protective Services (CPS) unit of the New Jersey Department of Human Services.

2. A law guardian in New Jersey is appointed under N.J.S.A. 9:6-8.23 for any minor who is the subject of a child abuse or neglect proceeding. A law guardian is appointed to protect the minor's interests and help him express his wishes to the court. A law guardian is not a guardian ad litem. Law guardians are not intended to represent the best interests of the child. They are an attorney for the child, advocating for and expressing the child's desires to the court.

3. Michael is a fictional character created for the purposes of this Note. However, his story is based on similar cases and the general experiences of children victimized by parental high-conflict divorce.

4. Sean is a fictional character created for the purposes of this Note. However, his story is based on similar cases and the general experiences of children victimized by parental high-conflict divorce.

5. *See* L. v. G., 203 N.J. Super. 385 (1985). The court held that the relationship between siblings is an important and unique relationship. Children gain meaningful knowledge and experiences from fostering a relationship with their siblings. The court found the relationship between siblings to be irreplaceable. Furthermore, the court held that "siblings posses the natural, inherent and inalienable right to visit with each other," subject to the best interest of the children when they are not living with each other or placed in the same home.

6. *See* Linda D. Elrod, *Reforming the System to Protect Children in High Conflict Custody Cases*, 28 Wm. Mitchell L. Rev. 2 (2001).

7. *See* Janet R. Johnston, *Building Multidisciplinary Professional Partnerships with the Court on Behalf of High-Conflict Divorcing Families and Their Children: Who Needs What Kind of Help*, 22 Univ. Ark. Little Rock L. Rev. 453 (2000).

8. *Id*.

9. *Id*.

10. *Id*.

11. *Id*.

12. Solly Dreman, *The Influence of Divorce on Children*, 32 J. Divorce & Remarriage 41 (2000).

13. Janet R. Johnston, *High-Conflict Divorce*, 4 Child & Divorce 165 (1994).

14. *See* Morgan v. Getter, 441 S.W. 3d 94 (Ky. 2014) (The court held that "the duties of a guardian ad litem ('GAL') shall be to advocate for the child-client's best interest in the proceeding through which the GAL was appointed." The Family Court Rules of Procedure provide for the appointment of a GAL for the child in custody, shared parenting, visitation, and support proceedings. If the attorney's understanding of the child's best interests are in conflict with the child's wishes, the GAL shall inform the court of the conflict and indicate the child's wishes and reasoning. In the holding the court acknowledges the differences that exist across jurisdictions with regards to the appointment of a GAL or attorney for the child, and under which circumstances they are permitted.).

15. *See* Diane Somberg, *Defining the Role of Law Guardian in New York State by Statute, Standards and Case Law*, 19 Touro L. Rev. 530 (2014) ("In New York State, the Family Court Act ("FCA") states that minors involved in proceedings that originated in family court need to be represented by counsel." The article continues by listing the types of cases covered under the FCA including: child abuse or neglect cases, termination of parental rights applications, adoption applications, requests for an abortion where parents have not given consent to their pregnant daughter, civil commitment proceedings, child custody disputes, juvenile delinquency hearings, persons in needs of supervision (PINS) proceedings, and medical treatment issues. Accordingly, in New York a law guardian is an attorney for the child, which is different from a GAL. A law guardian in New

York State is an advocate as well as a GAL with a statutory mandate to represent the child's wishes and best interests. In New York a law guardian is required to be assigned for any case involving abuse and neglect, termination of parental rights, juvenile delinquency, and PINS cases.).

16. *See* ANN M. HARALAMBIE, THE CHILD'S ATTORNEY: A GUIDE TO REPRESENTING CHILDREN IN CUSTODY, ADOPTION, AND PROTECTION CASES (1993) (discussing the difference between the role of a GAL and an attorney for the child in the representation of children in parental conflict situations).

17. Jay Lebow & Kathleen Newcomb Rekart, *Integrative Family Therapy for High-Conflict Divorce with Disputes Over Child Custody and Visitation*, 46 FAM. PROCESS 79, 79–91(2006).

18. *See* Johnston, *supra* note 7.

19. *Id*.

20. *See* Elrod, *supra* note 6.

21. *See* Johnston, *supra* note 13. The nature of disputes and the personalities of parties may contribute to the likelihood of a divorce being high conflict.

22. *Id*. Feelings stemming from sadness, disappointment, and an inability to let go or acknowledge the end of the relationship may lead to repetitive litigation as one or both parties attempt to hold on to the imploding relationship. Several explanations exist for why certain couples are more prone to high-conflict dissolution. For example, the history of the marital relationship and the nature of the separation can cause couples to create "negative, polarized views of each other," which furthers the contentiousness of the divorce process. This article describes the nature of some prior relationships as creating extreme distrust between parties. Accordingly, this causes some parents to fight zealously to protect the children from what they perceive as the negative aspects of the other partner.

23. *See* Elrod, *supra* note 6, at 6–10.

24. *Id*. at 7.

25. *Id*.

26. *Id*.

27. *Id*.

28. *See* Johnston, *supra* note 13, at 171.

29. Lebow & Rekart, *supra* note 17.

30. *See* Johnston, *supra* note 13.

31. Michael E. Lamb et al., *The Effects of Divorce and Custody Arrangements on Children's Behavior, Development, and Adjustment*, 35 FAM. & CONCILIATION CTS. REV. 4 (1997). Parents are often unable to focus on the needs of the children because they are preoccupied by their own financial, emotional, and social stress.

32. Elizabeth S. Scott, *Divorce, Children's Welfare, and the Culture Wars,* 9 VA J. SOC. POL'Y & L. 95 (2001) The article discusses different views regarding how the emotional and physical welfare of a child is affected by high-conflict marriage and divorce. Within this article Scott references the longitudinal study of families by Paul Amato and Alan Booth. Although children are typically better off when their parents decide to end high-conflict marriages, the study suggests, "a surprisingly high percentage of marriages that end in divorce involve low or moderate levels of conflict." Accordingly, these marriages are "good enough" and have seriously negative impacts on the long-term well being of the children involved. A child is only better off when their parents divorce, if the marital relationship was marked by high-conflict.

33. *Id*. Children are generally better off when parents chose to end a high-conflict marriage.

34. Joan B. Kelly, *Children's Adjustment in Conflicted Marriage and Divorce: A Decade Review of Research*, 39 J. AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY 963 (2000).

35. Lebow & Rekart, *supra* note 17, at 79.

36. *See* Kelly, *supra* note 34, at 964.

37. *Id*. at 966. Girls and boys exhibit slight variations in the type and degree of problem behaviors. Boys are more likely to exhibit external behaviors such as "being suspended or expelled from school, getting in trouble with the police, or running away from home." *Id*.

38. *Id*.

39. *Id*. at 964. The article describes the different types of conflict and how it creates different emotional issues for children. For example, overt hostile conflict such as physical abuse or screaming causes externalizing behaviors in children. Covert conflict styles such as passive aggressive behaviors, unspoken tension, and resentment were linked to depression, anxiety, and other internalizing symptoms in children.

40. *Id*.

41. John H. Grych & Frank D. Fincham, *Marital Conflict and Children's Adjustment: A Cognitive-Contextual Framework*, 108 PSYCHOL. BULL. 267 (1990).

42. *Id*.

43. *Id*. at 275.

44. *See* Kelly, *supra* note 34, at 965.

45. *Id*.

46. *Id*. at 967.

47. *Id*. (stating substance use can be attributed to less effective coping skills, impaired parental monitoring and flawed parenting skills).

48. *Id*.

49. *Id*. at 965.

50. *Id*.

51. *Id*.

52. *See* Johnston, *supra* note 13, at 172.

53. *See* Kelly, *supra* note 34, at 967. The article reiterates the importance of the paternal role in parenting that is often jeopardized during divorce. Studies show when fathers remain involved in the child's academic life the child is more likely to perform better academically and avoid disciplinary issues at school.

54. *Id*. Lower academic achievement can be attributed to financial resources and parental monitoring being jeopardized during and after dissolution.

55. *See* Lamb et al., *supra* note 31, at 394.

56. *See* Grych & Fincham, *supra* note 41.

57. *See* Johnston, *supra* note 13; *see also* Kelly, *supra* note 34 (describing how adequate family functioning is often impaired when depression and/or anxiety color a parental mindset).

58. *See* Johnston, *supra* note 13. The article reiterates parental distress and continued conflict between parents often creates more strain for the parent-child relationship. Typically the relationship is already strained due to the inevitable shift in family dynamic during any family rearrangement. Not only does this stress make it more difficult for a child to adjust to the divorce, but it may also lead to more severe behavioral, developmental, and emotional complications for the child.

59. Kelly, *supra* note 34, at 967.

60. *See* Lamb et al., *supra* note 31, at 395.

61. *Id*.

62. *See* Kelly, *supra* note 34.

63. *Id*.

64. *Id*.

65. Sandra J. Kaplan et al., *Child and Adolescent Abuse and Neglect Research: A Review of the Past 10 Years. Part I: Physical and Emotional Abuse and Neglect*, 38 THE J. OF THE AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY 1214 (1999).

66. Jocelyn Brown et al., *Childhood Abuse and Neglect: Specificity of Effects on Adolescent and Young Adults*, 38 THE J. OF THE AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY 1490 (1999).

67. Joan McCord, *A Forty Year Perspective on Effects of Child Abuse and Neglect*, 7 CHILD ABUSE & NEGLECT 265 (1983). The article describes the outcomes of a study of abused and neglected boys. The study found abuse and neglect caused antisocial behaviors leading to increased rates of juvenile delinquency within this group. Additionally, paternal alcoholism, crime, and aggression facilitate a strong likelihood of continuing physical abuse and neglect.

68. *See* Brown et al., *supra* note 66. The authors reiterate disruptive family systems and inadequate parenting often contribute to maladjustment for children of abuse and neglect. Physically abused and neglected children often have delays in health, cognitive development, emotional adjustment, and socialization. Adverse family environments and specific characteristics of parent-child relationships often explain the link between childhood abuse and depression.

69. *Id*. Parents who are suffering with mental illness may be unable to control the abuse if it is being performed by their spouse or another caregiver. Additionally, parents may be blind to the abuse if they are preoccupied with their own issues, leaving the children without any protection within the home. Alternatively, parents may be performing the abuse due to their mental health issues.

70. *See* McCord, *supra* note 67, at 268; *see also* Brown et al., *supra* note 66 (The article indicates childhood abuse makes an individual three to four times more likely to be abused or suicidal in the future. Adults who were abused as children typically are at an increased risk for distress, mental health disorders, depression, and suicidal ideations).

71. KIERAN O'HAGAN, IDENTIFYING EMOTIONAL AND PSYCHOLOGICAL ABUSE: A GUIDE FOR CHILDCARE PROFESSIONALS (2006).

72. *Id*. at 25.

73. Danya Glaser, *Emotional Abuse and Neglect (Psychological Maltreatment): A Conceptual Framework*, 26 CHILD ABUSE & NEGLECT 697 (2002).

74. *Id*.

75. Judith C. Areen, *Intervention Between Parent and Child: A Reappraisal of the State's Role in Child Neglect and Abuse Cases*, 63 GEO. L.J. 887 (1975). The parens patriae power allows the state to protect children from abuse and neglect at the hands of their parents or caretakers.

76. Douglas J. Besharov, *"Doing Something" About Child Abuse: The Need to Narrow the Grounds for State Intervention*, 8 HARV. J.L. & PUB. POL'Y 539 (1985). The author discusses the history of CPS. The article states Vincent DeFrancis of the American Humane Association and Dr. Vincent J. Fontana of the New York Foundling Hospital were strong advocates for the creation of a centralized agency to receive and investigate reports of abuse and neglect). CPS is responsible for receiving and investigating allegations of child abuse and neglect.

77. *Id*. at 548. The Child Abuse Protection and Treatment Act was passed when national recognition and mass media coverage of child fatalities resulting from unreported and uninvestigated abuse became widespread. Additionally, the federal government encouraged the creation of CPS agencies by allocating grant money for the creation of these programs.

78. *See* Besharov, *supra* note 76, at 548; *see also id*. at 542 (discussing reporting laws requiring "certain" professionals to report instances of suspected child abuse; by 1967 all states had laws requiring physicians to report all physical injuries inflicted on children caused by nonaccidental means); How and When to Report Child Abuse/Neglect, N.J. Dep't Child &

Families, http://www.nj.gov/dcf/reporting/how/ (last visited Nov. 22, 2015) (describing the process for making reports of abuse and neglect to CPS). As indicated by Besharov, *supra* note 76, all states have anonymous hotlines for individuals to report child abuse and neglect. For example, in New Jersey the hotline is 1-877 NJ ABUSE. Any person that reasonably believes a child to be subject to abuse should call the hotline.

79. *See* Besharov, *supra* note 76, at 545.

80. *How and When to Report Child Abuse/Neglect*, *supra* note 78.

81. *Id*.

82. *See* Besharov, *supra* note 76, at 549.

83. *Id*.

84. *Id*. CPS generally helps a family obtain services including financial assistance, therapy, or parenting classes.

85. *See id*. The author discusses the possibility that parents or caregivers may not be compliant or cooperative with services. In such cases, court intervention is necessary to implement care plans/services. According to this article only about fifteen percent of substantiated cases result in civil court actions to enforce services. Similarly, less than five percent of cases result in criminal prosecution.

86. Andrea J. Sedlak et al., *Child Protection and Justice Systems Processing of Serious Child Abuse and Neglect Cases*, 30 CHILD ABUSE & NEGLECT 657 (2006). This article discusses the different roles of CPS and law enforcement in dealing with allegations of abuse and neglect. This article indicates it is up to the prosecutor to determine whether or not to prosecute a case for child abuse. Typically court involvement is limited to civil or family court intervention to require participation in the therapeutic interventions recommended by CPS. These interventions include recommendations to family or individual therapy.

87. *Id. at* 660. CPS will petition the court for the power to provide care and supervision of the child if they remain in the home in order to ensure compliance with therapeutic interventions and continual safety plans.

88. *Id*. at 660.

89. *See* Areen, *supra* note 75, at 927. Mental health and social science experts are well aware of the effects of emotional neglect on children.

90. *See* Glaser, *supra* note 73, at 697.

91. *Id*. at 699.

92. *Id*. at 698.

93. Kaplan et al., *supra* note 65.

94. *See* Glaser, *supra* note 73.

95. *Id*. at 705.

96. *Id*.

97. Patrick T. Davies & E. Mark Cummings, *Marital Conflict and Child Adjustment: An Emotional Security Hypothesis*, 116 PSYCHOL. BULL. 387 (1994).

98. *See* Areen, *supra* note 75. When parents are unable to provide adequate emotional support due to personal preoccupation, they continuously place their children in stressful situations.

99. *See* Lamb et al., *supra* note 31.

100. *Id*.

101. *See* Kelly, *supra* note 34, at 964 (describing the emotional effects of high conflict divorce on children); *see also* Kaplan et al., *supra* note 65 (discussing the lasting social, emotional, and educational effects of physical abuse and neglect on children).

102. Kelly, *supra* note 34, at 964. Children of divorce are also generally more at risk for depression as young adults similar to children who are physically abused and neglected; *see also* Brown et al., *supra* note 66 (describing the lasting effects of physical abuse and neglect on children); *see also* Kelly, *supra* note 34, at 964 (describing the effects of high conflict divorce on children).

103. *See* O'HAGAN, *supra* note 71, at 17. The author describes a case where a caseworker attempted to bring a case against a parent for emotional neglect. Supervisors at CPS requested the caseworker indicate what physical injuries the child sustained. The caseworker observed emotional neglect that was substantiated by the observations of other professionals, however, in order for a case to be opened a bruise on the child's body had to be used as evidence of physical abuse. This section of the chapter indicates caseworkers are enticed to only pursue physical abuse and neglect. The point of this story is to show CPS is unlikely to open a case for emotional neglect, because it is hard to prove, define, and identify. Therefore, emotional neglect often is unreported and unsubstantiated.

104. *See generally* Areen, *supra* note 75, at 927. In fact, some courts have specifically indicated emotional danger has no place in neglect proceedings.

105. *Id.; see also* Johnston, *supra* note 13, at 168 (stating although allegations of neglect or abuse are often made during high-conflict dissolution, they are often dismissed by CPS workers because they feel they are only "indicators of inter-parental spite, impossible to prove, or insufficiently serious to require state intervention").

106. *Id*. at 903.

107. *Id*. at 912.

108. *Id*. at 927–28.

109. *Id*. at 928.

110. *See* Glaser, *supra* note 73.

111. *Id*. at 698. The state must exercise its parens patriae power to intervene on behalf of the children in these cases.

112. *Id*. at 705. CPS must be responsible because courts, lawyers, and laypersons are often unable to identify emotional neglect.

113. *Id*.

114. Christine A. Coates et al., *Parenting Coordination for High-Conflict Families*, 41 FAM. CT. REV. 1 (2003). The number of high-conflict divorce cases is relatively low. The number of cases, which will be statutorily required to be referred for CPS investigation after eighteen months of litigation, will be an even smaller percentage. Coincidentally, the number of cases requiring further court intervention and the appointment of an attorney for the child will be even smaller. Therefore, it is argued the burden of protecting the children will not have grave repercussions on the functioning of the court or CPS.

115. *Id*. Additionally, parents continue to emphasize their destructive opinions of each other, which inflicts further emotional harm on the children.

116. *See* Areen, *supra* note 75.

117. *Id*. at 903; *see also* Kristen Shook Slack et al., *Understanding the Risks of Child Neglect: An Exploration of Poverty and Parenting Characteristics*, 9 CHILD MALTREATMENT 395 (2004).

118. *Id*.

119. *See* Glaser, *supra* note 73.

120. *See* Areen, *supra* note 75.

121. *See* Glaser, *supra* note 73; *see also* Lamb et al., *supra* note 31.

122. *See* Areen, *supra* note 75, at 933. This article discusses the importance of specifically defining emotional health in a model statute. This article proposes intervention be supported by evidence the child is suffering from a specific list of mental health disorders including anxiety, depression, withdrawal, aggression, or hostility. Additionally, the article argues for an exhaustive list of signs and symptoms to support a finding of emotional neglect.

123. *See* Johnston, *supra* note 13, at 171 (describing high-conflict divorce as marked by repetitive litigation perpetuated based on extreme levels of mistrust, anger, aggression, and hatred between parties); *see also* Areen, *supra* note 75. The emotional effects on children may not be recognizable to lawyers, judges, or parents.

124. *See generally* Areen, *supra* note 75.

125. *See How and When to Report Abuse/Neglect, supra* note 78.

126. Glaser, *supra* note 73, at 705. When family dynamic is a cause for concern, for example, in high-conflict martial relationships, there is a need for investigation to determine whether there is emotional neglect.

127. *See* Lamb et al., *supra* note 31. This article discusses the nature of divorce in general and arguing parents become less likely to gainfully or productively contribute to the emotional needs of their children based on their own inability to appropriately deal with the traumatic divorce experience. Additionally, these stressors are extenuated and more harmful to the children in high-conflict cases.

128. *See* Kelly, *supra* note 34, at 964 (describing the presence of the listed factors as more likely to be exhibited by children involved in high-conflict marriages and divorces as opposed to children from low-conflict marriages, and subsequent divorces).

129. *Id*. When intense parental conflict is centered around issues such as child care, support, parenting time, or the children's activities, generally, children are more likely to feel shameful, to blame, or fearful of the outcome of the conflict.

130. *Id*. at 967.

131. *See* N.J. DEP'T CHILD. & FAMILIES, *supra* note 80.

132. *See* Besharov, *supra* note 76; *see also* Sedlak et al., *supra* note 86. The role of CPS with regards to emotional neglect cases will be no different than a traditional physical abuse or neglect case. CPS will use therapeutic interventions and operate from a social work perspective.

133. *Id*.

134. *See* Glaser, *supra* note 73. Parents may not be aware because they are preoccupied with the divorce process.

135. Sedlak et al., *supra* note 86, at 660.

136. *See* Somberg, *supra* note 15, at 533 (explaining the right to counsel was extended to children with the passing of CAPTA; CPS agencies were only entitled to federal aid if state legislatures enacted laws ensuring a child involved with CPS proceedings would be granted a GAL).

137. Some states have already started implementing similar programs. However, this Note advocates for nationwide protection for children in high-conflict dissolution proceedings.

138. *See* O'HAGAN, *supra* note 71, at 25. The author discusses the failure of child welfare systems to address emotional neglect unless it is attached to physical abuse or neglect. Further arguing most supervisors in child welfare organizations require a finding of physical abuse or neglect to open cases and provide services to families.

139. *See* Johnston, *supra* note 13.

140. Areen, *supra* note 75, at 927.

141. Wilma J. Henry et al., *Parenting Coordination and Court Relitigation: A Case Study*, 47 FAM. CT. REV. 682 (2009).

142. Coates et al., *supra* note 114.

143. *See* Henry et al., *supra* note 142 (This article discusses the relationship between long, drawn out, court involvement and the serious emotional and behavioral effects it has on children and their relationship with "one or both of their parents." Reiterating the point that high-conflict divorce often poses "substantial emotional risk and psychological harm to the children who are victims of the resulting parental discord.").

144. *Id.; see also* Glaser, *supra* note 73. As parents become more entrenched in the emotional, financial, and social stress of high-conflict divorce, especially when conflict continues for extended periods of time, they become less likely to sustain strong emotional or even physical ties to the children. Parents become less likely to acknowledge the toll the high-conflict divorce is taking on a child's emotional well-being.

145. Areen, *supra* note 75.

146. Glaser, *supra* note 73.

147. *Id*.

148. *Id*. at 699; *see also* Lebow & Rekart, *supra* note 17. Although the number of high-conflict divorces as compared to the total number of divorces in the United States is relatively low, almost two million children in the past two decades have been victimized by high-conflict parental dissolution.

149. *See* O'Hagan, *supra* note 71, at 25.

150. *See* Areen, *supra* note 75. Trained caseworkers with a social work background can conduct an investigation to determine the possibility and/or existence of emotional neglect.

151. *See* Haralambie, *supra* note 16. Appointment of an attorney for the child (AFC) is commonplace in physical abuse and neglect cases.

152. Henry et al., *supra* note 142; *see also* Johnston, *supra* note 7. Although proportionality small in number, these cases are not only detrimental to the emotional health of the entire family unit, but also consume a "disproportionate amount of the court's time and resources."

153. *See* Elrod, *supra* note 6.

154. *See* O'Hagan, *supra* note 71; *see also* Glaser, *supra* note 76; *see also* Johnston, *supra* note 7.

155. *Id*. at 683. This amount takes into consideration the costs associated with acts of juvenile delinquency performed by children of divorce.

156. *Id.; see also* Johnston, *supra* note 7. The author discusses how this small group of divorcing couples uses a disproportionate amount of the court system's resources with grim legal outcomes. The longer a case is open, the more money the court system and taxpayers are forced to pay.

157. *Id*.

158. Sean and Michael are two fictional characters created for the purpose of this Note. Their story is based on similar cases observed in family court proceedings where there was high conflict and emotional neglect.

Alexa would like to thank her family, friends, and employers for their continued support, patience, and inspiration.

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SPECIAL ISSUE ARTICLE

Defining points and transformative turns in family violence, parenting and coparenting disputes

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Abstract

Family violence is a multifaceted issue encompassing various harmful behaviors within familial relationships. This paper explores the definitional problems presented in this special issue on family violence and its impact on parenting and coparenting. By examining the shifts and expansions of concepts related to family violence over time, we highlight the transformative turns in this special issue that have helped us to clarify our understanding of family violence. We explore the transformative expansions of family violence by situating this exploration within a "concept creep" analysis. We make a note of the underlying assumptions associated with these concepts. Through an analysis of concept creep, we elucidate how the expansions and redefinition of violence-related terms have influenced our understanding of family violence. By differentiating family violence, intimate partner violence, and maltreatment, we emphasize the necessity of unpacking these terms to avoid oversimplification or overlooking certain forms of violence that may go unnoticed under narrow definitions. The authors further highlight the need for interdisciplinary collaboration to address the complexities of family violence and its impact on parenting and coparenting. By acknowledging and responding to expansions of concepts in family violence, we can strive to protect and support children in these

challenging circumstances, ultimately promoting their well-being and creating safer family environments.

KEYWORDS
child safety, concept creep, coparenting, family law, family violence, parenting

Key points for the family court community

- Family violence is a hypernym for various forms of violence and abuse that can impact intimate relationships.
- Concept creep provides a framework for understanding family violence concepts' horizontal and vertical expansions over time and its impact on parenting and coparenting.
- Due to the complexity of family violence, a systematic approach must thoroughly screen, assess and intervene to ensure the safety and well-being of all family members.
- An ecological approach to family violence emphasizes the various interrelated levels that impact and influence the consequences of violence within families.

DEFINING FAMILY VIOLENCE

Family violence is a multifaceted and complex family law issue that occurs within the intimate spaces of households, impacting individuals of all ages and relationships. Family violence is any form of abuse, maltreatment, or neglect perpetrated towards another family member, including adults and children within the family system (Department of Justice Canada, 2022). Numerous conceptual frameworks have been developed to better understand family violence by focusing on the various types, causes, and frequency (Rossi et al., 2016). Violence and abuse can occur across multiple family relationships and contexts, including intimate partner violence (IPV), child maltreatment, elder abuse, and pet abuse (Department of Justice Canada, 2022). Violence and abuse within the family system can include physical, sexual, psychological, emotional, and economic abuse. Numerous conceptual frameworks have been developed to better understand family violence by focusing on the various types, causes and frequency (Rossi et al., 2016). Differences in the context and consequences of violence can have implications for addressing safety issues within parenting plans (Drozd & Saini, 2019).

In this special issue on family violence, several definitions of violence have been proposed, focusing on intimate relationships or relationships between and among multiple family members. Nonomura et al. (in this issue) focus on legislative changes in Canada that have helped to reshape the definition of family violence to include any form of abuse within a family that provides for IPV and child abuse, including exposing children to IPV. Sullivan et al. (in this issue) define family violence as "an umbrella term" for the various kinds of violence within family dynamics, including IPV, child maltreatment and neglect, and behaviors that attempt to undermine the child's relationship with the other parent. Davis et al. (in this issue) emphasize that family violence is not limited to any specific demographic or socioeconomic group and can occur across diverse family structures.

Several recent attempts have been made to expand the concept of violence to be more inclusive of diverse family dynamics. For example, scholars have emphasized that family violence can occur within the diversity of significant interpersonal relationships, including intact and separating husband and wife relationships, girlfriend and boyfriend dating relationships, gay, lesbian, transgender and non-binary partners, parents and children, and adult children and elderly parents (World Health Organization, 2002; Huss, 2009).

By defining violence, the APA Task Force on Violence and the Family focused on patterns of abusive behaviors (e.g., physical, psychological, emotional, sexual, economic) that are used to gain power over the other, maintain the misuse of power, and control the other (as cited by Rakovec-Felser, 2014). Hardesty et al. (this issue) emphasized behaviors in intimate relationships that cause physical, sexual, or psychological harm based on the World Health Organization (WHO, 2022) but also noted the importance of distinguishing coercive controlling violence (CCV) from situational couple violence (SCV). Rossi et al. (this issue) relied on a definition by Breiding et al. (2017). This definition focuses on IPV and describes it as physical or sexual violence, stalking, psychological aggression, or coercion by a past or current intimate partner.

O'Leary (in this issue) suggests that no single agreed-upon classification system defines family violence. Rather than illustrate violence or abuse, Ponting et al. (in this issue) focus on the risk factors associated with the risk of violence. O'Leary (in this issue) focuses on the association between family violence and substance misuse. Davis et al. (in this issue) emphasize the role of judicial decision-making when family violence is a factor in determining parenting time and implications related to remote technologies.

In summary of the articles in this special issue, it can be postulated that the complexity of family violence arises from various factors, such as power imbalances, societal norms, cultural influences, and individual characteristics (Hardesty & Ogolsky, 2020), but, as Davies (in this issue) noted, the consequences of family violence extend beyond immediate harm, permeating the emotional well-being, relationships, and overall functioning of individuals and entire family systems, including, more specifically, the impact on parenting, coparenting, and child adjustment.

Ponting et al. (this issue) also point out that there remains little consensus regarding a universally accepted definition of children's exposure to IPV. Family law has moved from describing a "child witness of violence" (Aitken, 1998) to a "child exposed to violence" (Holden, 2003) to better reflect the different types of violence children experience beyond simply observing the violence. Holden (2003), for example, suggests other forms of exposure, including prenatal exposure, victimization, participation, eyewitness observation, overhearing, observation of the initial effects, experiencing the aftermath, and hearing about the violence. Ponting et al. (this issue) encourage the broad definition of children's exposure to IPV as the more inclusive approach. This broad definition of children's exposure to IPV is consistent with the United Nations (UN) Convention on the Rights of the Child, which has recognized that children should be protected from harm and that they have a universal right to live free from all forms of violence (Convention on the rights of the child, 1989, Article 19).

THE ROLE OF LANGUAGE AND LABELS IN PERCEPTIONS OF VIOLENCE

Language and labels are crucial in shaping perceptions of violence and abuse within society (Wilcox, 2008). How we conceptualize, describe, and label acts of violence and abuse influences how we perceive and respond to them. Language reflects societal attitudes and values and has the power to shape and reinforce those attitudes (Rakovec-Felser, 2014). The use of language can either normalize or condemn specific acts of violence and patterns of abuse. Descriptive and accurate language of violence and abuse can convey the gravity and harm of these violent acts, bring awareness to acts of violence, and foster a sense of urgency for addressing the issue. In contrast, euphemistic or dismissive language related to violence can downplay the severity of an act of violence and deny harm's impact on individuals (Walker et al., 2021).

Labels attached to different forms of violence and abuse impact how we understand and respond to perceptions of harm. Specific labels, such as domestic abuse, IPV, or child maltreatment, not only categorize and differentiate

various types of violence but also highlight the particular dynamics and contexts in which they occur (Walker, 1999). Language and labels also influence perceptions of "victims" and "perpetrators" (Wilcox, 2008). The terms used to describe individuals involved in violent incidents can shape societal attitudes towards them. Victim-blaming language, for example, can perpetuate harmful stereotypes and shift the focus onto the victim (Clark, 2021), hindering support and empathy towards victims and contributing to the underreporting of violence (Heckert & Gondolf, 2000).

MOVING TOWARDS INCLUSIVE LANGUAGE GUIDELINES REGARDING FAMILY VIOLENCE

In 2021, the American Psychological Association (APA) issued *Inclusive Language Guidelines* to be used in conjunction with the *American Psychological Association Publication Manual, 7th edition* (2020). The Guidelines were developed to further equity, diversity and inclusion (EDI) by using language that fosters inclusivity, respect, and safety in all environments (American Psychological Association, 2021). The Guidelines focus on marginalizing and harmful words and person-first versus identity-first language, emphasizing the person's choice of defining their identity rather than allowing others to define the person by their chosen label.

Consistent with these Guidelines and wanting to raise awareness of the possibilities for change and address marginalization and stereotypes that accompany experiences such as family violence, we asked the authors of the papers in this Special Issue to use inclusive language consistent with these guidelines. Specifically, we asked them to avoid terms such as victim and perpetrator, instead using a person who experienced or has been impacted by violence and who uses violence. Through these language changes, we could also focus on the actual impact of family violence on factors such as parenting, coparenting and child adjustment, as well as evidence-informed interventions that take into consideration an ecological perspective and the ripples of effect from the individual to the family system to the community.

CONCEPT CREEP: EXPLORING SHIFTING DEFINITIONS

Language and labels are not static. They evolve as societal attitudes change and knowledge grows (Rakovec-Felser, 2014). As our understanding of violence and abuse expands, the language and labels must reflect these advancements. Regular evaluation and terminology revision are necessary to ensure they accurately represent changing societal trends. For example, cyber abuse, cyber harassment, and cyber stalking are recent expansions of the concepts of violence to address the virtual interactions among family members and the increased dependence on technology for communication and social connection. Another example is the concept of cyberbullying, which was expanded from the idea of bullying (Mishna et al., 2012).

While these expansions of harm can be considered both normal and positive evolution of concepts based on changing societies, we must also be mindful of the potential negative impact of increasing notions of harm. The term concept creep was first described by Haslam (2016) in psychology as a framework for understanding the growing expansion of harm-related terms (e.g., the inclusion of cyber abuse as an expansion of the concept of violence and abuse). Haslam et al. (2020) suggested that while expanding concepts of harm can identify new forms of harm previously unrecognized, broadening definitions also have the danger of diluting or even changing the meaning of original concepts. Concept creep has helped shed light on previously overlooked forms of violence within families (e.g., emotional harm, cyber abuse, legal abuse), drawing attention to how individuals can experience harm within intimate relationships. Recent conceptual frameworks have isolated, for example, coercive and controlling dynamics to safeguard against these most devastating forms of violence. Hardesty noted (this issue) that different forms of violence and abuse would likely require different interventions to address the unique factors of the various forms of violence and abuse.

The Wingspread conference (Ver Steegh & Dalton, 2008) provided the opportunity to consider the expanding forms of violence and abuse that impact families in the context of family law (Jaffe et al., 2008). It helped to bring attention to these expansions by situating them within a classification schema that includes the different forms of violence and abuse, including Coercive Controlling Violence, Violent Resistant, Situational Couple Violence, and Separation-Instigated Violence (Jaffe et al., 2008; Kelly & Johnson, 2008).

Austin and Drozd (2012) created an integrated conceptual framework for the expansion of violence and abuse concepts in the context of parenting plan disputes, in which they urged parenting plan evaluators to approach assessment using a systematic method for considering the following:

1. Risk factors (e.g., history of previous violence, substance misuse, major mental disorders, and threat assessment factors).
2. Kind of aggression (e.g., physical, emotional/psychological, and coercive control).
3. Pattern, frequency, severity, and the nature of the child's exposure.
4. Pattern of instigation (e.g., primarily male, primarily female, mutual, defensive or reactive, involving multiple instigators).

By focusing on the expansions of concepts on a continuum, the Austin and Drozd (2012) conceptualization emphasizes the value of considering violence-related factors by assessing violence's patterns, frequency, and severity instead of focusing just on categories. This approach facilitates a comprehensive assessment of violence and abuse that integrates the fit between the unique experience of each family member and the effect of family violence more broadly on the children, parenting, and coparenting. Connecting assessment plans to parenting plans is essential, given the little attention in the social science research that connects the various forms, patterns, and contexts of violence to preferred parenting plans for optimal safety and well-being among family members.

As our understanding of the risks, consequences, and impacts of violence and abuse has evolved, new terms and concepts have been added to include the expansion of harm. As mentioned above, violence and abuse have expanded to include cyber abuse within a family or intimate partner relationship. Cyber abuse typically involves using digital technology, such as smartphones, social media, email, or other online platforms, to harass, threaten, control, or intimidate a family member or intimate partner. This type of abuse can take various forms, including sending threatening or derogatory messages through text, email, or social media to a family member or partner; using technology to track the victim's online activity, location, or movements without their consent; sharing explicit or intimate images or videos of a family member or partner without their permission, often with the intent to humiliate or harm them; manipulating or controlling a partner's online presence, such as forcing them to share passwords or monitoring their online interactions; engaging in cyberbullying behavior within a family context, where one family member bullies or harasses another using digital means; pretending to be the victim online and posting false information or making false statements to harm their reputation or relationships; or using technology to isolate the victim from friends and family by controlling their access to social media or communication platforms (Al-Alosi, 2017). Cyber abuse can have severe emotional, psychological, and even physical consequences for the victim, violating their privacy and personal boundaries (Woodstock et al., 2000).

Hardesty (this issue) also highlights the recent trend towards expanding the concept of coercive control to include "legal abuse" as a form of violence that intentionally misuses the court processes to continue to control former partners (Gutowski & Goodman, 2023). Hardesty (this issue) suggests that examples of legal abuse can include prolonging litigation with frivolous motions, forcing in-person contact at court, seeking full custody to retain control, making false allegations of abuse to gain an advantage in a legal dispute and portraying a parent as unfit or hostile to gain a tactical advantage in the court. Legal abuse can have significant emotional, psychological, and financial consequences for those impacted by violence.

Another example of the suggested expansion of violence is found in the paper by Sullivan et al. (this issue), in which they seek to include severe parental alienating behaviors (PABs) as a form of family violence. While highly

controversial, the authors make a compelling argument for expanding concepts of violence to include the most severe behaviors that could potentially cause harm to the child, including cognitive processing, physical health, emotional regulation, and interpersonal relationships. While the authors limited their focus to severe PABs, there is the risk that others will expand the definition of family violence to include all PABs, thus diluting the severity of other violent acts (e.g., IPV) or blurring the boundaries between different types of harm (Haslam, 2016). Not all behaviors identified within the grouping of PABs would be considered violent. For example, while there tends to be general support in the literature that denigrating a parent is psychologically harmful (Hibbard et al., 2012), not all of Baker and Fine (2013) documented 17 parental alienating behaviors would fit within current definitions of violence and/or abuse. For example, asking the child to refer to a step-parent as "mom" or "dad" may not be optimal or even appropriate, but it would be semantic inflation to suggest that this is abusive. Baker and Fine (2013) explained that "taken together, the 17 parental alienation strategies work to create psychological distance between the child and the targeted parent such that the relationship becomes conflict-ridden" (p. 94), and these form the concept of PABs.

The broadening of violence to include PABs has the potential to inflate the occurrence of parent–child contact problems, making it more challenging to effectively assess, identify, and address specific forms of violence. One of the risks of including PABs under the family violence umbrella is that doing that may be and is likely to be used as a weapon in the all-or-nothing war between abuse and alienation, as those on the extremes use words to weaponize their arguments that further divide us. It may also lead to variations in interpretations and inconsistencies in applying interventions and legal responses. Including PABs also has the risk of treating all forms of violence as the same, diminishing the impact of IPV or child maltreatment when the types, patterns, severity, frequency, and impact on the child's development and functioning of the PABs are not considered. Moreover, given the current adverse political climate between extreme advocates and the false binary causal pathways of parental alienation or intimate partner violence on PCCP, and semantic inflation of PABs as a form of family violence may thus result in the definition being intentionally, even maliciously, exploited in courtrooms and legislatures, potentially causing even greater harm and confusion among practitioners, policymakers, and researchers.

To navigate the potential risks of concept creep, it will be necessary for family law professionals to carefully screen for the types and patterns of behaviors that could be harmful and to be clear on the use of terms so as not to inflate harm or to silence the importance of safety and protection from harm.

With all these new and emerging trends towards expanding concepts of violence and abuse, it is essential to balance inclusiveness and clarity. Continual dialogue, research, and refinement of definitions are necessary to ensure that the expanded understanding of violence and abuse remains grounded in empirical evidence, cultural context, and the experiences of those affected. Exploring shifting definitions due to concept creep enables us to better understand the complexity of violence within family settings. It prompts us to critically examine the evolving nature of violence and its manifestations, encouraging a comprehensive approach to addressing and preventing violence in all its forms.

TOWARDS DEFINITIONAL CLARITY: CHALLENGES AND IMPLICATIONS

Defining violence and abuse presents challenges due to the overlapping categories and blurred boundaries between different forms of violence. Often, acts of violence and patterns of abuse do not neatly fit into a single category, making it challenging to capture the full complexity of abusive behaviors (Drozd & Saini, 2019).

Addressing the overlapping categories and blurred boundaries within family violence is essential in navigating the challenges of definitional clarity. Hardesty (in this issue) points out that most of the literature fails to carefully distinguish types of family violence in favor of a broad definition of violence. They suggest that each form of violence and abuse should be carefully considered, given that various forms of violence and abuse can be harmful, even if they are understood differently within the context of these forms of violence. Rossi et al. (in this issue) affirm that it is critical that separating or divorcing parents be assessed for a history of family violence and ongoing safety concerns.

To achieve definitional clarity, it is crucial to consider the importance of contextual understanding and intersectionality (Cardena, 2023). Crenshaw (1989) coined the approach to understanding family violence by recognizing structural sources of inequality as intersectionality. This approach poses that people's identities (i.e., race, class, sex, and gender) interact with systems of oppression to create unique experiences (Collins, 1998). As a result, researchers recognized the overlapping oppressions individuals of diverse backgrounds face and their impact on their IPV experiences (Sokoloff & Dupont, 2005). Family violence occurs within a social and cultural context, shaped by various factors such as gender, race, class, and sexual orientation. These intersecting identities influence the experiences of people who experience violence and those who use violence. A comprehensive understanding of family violence requires acknowledging these intersecting factors and recognizing that the manifestations and impacts of violence can differ based on an individual's unique circumstances.

Expanding definitions of family violence can have significant consequences, including underestimating and overestimating the prevalence and impact of family violence in individual cases and inadequate responses from the family law system. For example, scholars have criticized family law professionals (e.g., judges, mediators, parenting plan evaluators) for their lack of awareness and sensitivity to family violence issues, their overall lack of competency to detect family violence, and the limited use of procedures to screen for the potential presence of family violence (Ellis & Stuckless, 2006; Frederick, 2008; Hardesty et al., 2012; Ver Steegh et al., 2008). Rossi et al. (in this issue) note the consequence of practitioners lacking sufficient education on conducting family violence screening assessments, being able to interpret the results (Frederick, 2008; Saunders et al., 2011), and deciding which IPV tools to use in their practice. Given evolving concepts of violence and abuse, family law practitioners who are not receiving sufficient education about the expanding ideas of violence can provide their clients with outdated information.

Family law practitioners have also been criticized for not fully understanding and assessing the consequences of children's exposure to family violence when suggesting parenting plans to the courts (Jaffe et al., 2003; Rossi et al., this issue; Saini et al., 2019). Saini et al. (2013) found that the other parent made almost a third of family violence allegations reported to child protection services within parenting plan disputes. However, only a minority of these allegations were considered maliciously fabricated. Therefore, family law practitioners should avoid quick judgments about the complexity of these cases and not assume allegations are false. Similarly, it is essential for family law practitioners not to assume that allegations are true simply because they are reported (Drozd & Saini, 2019). Thus, family law practitioners should check any biases and collect, analyze, and synthesize data systematically and methodologically (AFCC, 2016; Rossi et al., this issue).

Section three of the AFCC IPV Guidelines (2016) suggests that a parenting plan evaluator should have in-depth knowledge of family violence's nature, dynamics, and impact. The guidelines state, "Because intimate partner violence frequently occurs in custody-litigating families and because it may be unidentified and difficult to detect, a custody evaluator will inevitably be involved in cases where intimate partner violence is or becomes an issue" (AFCC, 2016, p. 6). If an evaluator lacks knowledge in any area, the evaluator should seek relevant training, supervision, or professional consultation. We argue that all family law practitioners should receive adequate training and support to best work with the complexity of family violence. With changing and expanding definitions of violence and abuse, even those who were/are well trained might not be for long as the definitions and politics related to them are fluid. Moreover, simply using the term IPV or family violence without defining the nature, the context, and the implications fails to bring sufficient clarity required for labeling diverse forms of violence and abuse.

USING A SYSTEMATIC APPROACH

In 2016, the AFCC collaborated with the National Council of Juvenile and Family Court Judges (NCJFCJ) and, in consultation with the Battered Women's Justice Project (BWJP), to develop Guidelines for Examining Intimate Partner Violence for parenting plan evaluators, aiming to identify better the risk of family violence and its potential effects on children, parenting, and coparenting. While these guidelines were developed specifically for parenting plan evaluators, they promote a systematic approach relevant to all family law practitioners.

The Guidelines (2016) advocate for a systematic approach to evaluating family violence allegations in the context of family law disputes, considering each family's unique circumstances. It emphasizes the importance of approaching each case without preconceived biases about the impact of violence on children and parenting. The Guidelines suggest that family violence be independently analyzed, separate from other issues like mental health or substance abuse, focusing on its context and implications for safety, parenting, coparenting, and child well-being.

Adhering to this systematic approach has several benefits. It enhances the quality and accountability of the screening process, making the assessment of family violence more valuable to the parties involved and the court (Austin & Drozd, 2012; Drozd & Saini, 2019). It also prevents the imposition of the family law practitioner's assumptions, biases, or beliefs. Additionally, employing this approach can highlight any misapplication of dominant cultural norms related to family violence. The systematic approach also provides a framework to identify expanding forms of violence and abuse and clarify how these concepts apply to individual cases.

APPLYING THE ECOLOGICAL FRAMEWORK

Adhering to this systematic approach also fits with the ecological framework (Bronfenbrenner, 1979). The ecological framework highlights the interaction between human characteristics, personal development, and the environments in which individuals find themselves. Belsky (1980) and Cicchetti and Rizley (1981) expanded the ecological framework including four interconnected parts: macrosystem (culture), ecosystem (community), microsystem (family), and ontogenetic development (individual) (Belsky, 1980). By considering the multiple levels of influence within the ecological framework, including individual, relationship, community, and societal factors, evaluators can better understand the dynamics and complexities of family violence for a specific family (See Figure 1).

Identifying the ecology of violence and abuse can also assist in clarifying expanding concepts of harm by considering the interconnected parts and their interactions to investigate the etiology of violence and abuse, its influences, and the various factors that may be related to the presence of harm. The ecology of violence framework further assists in avoiding premature closure of a singular label or violence but instead urges for a systematic and comprehensive assessment of the various interactions that impact the severity, frequency, nature, and type of violence or abuse.

Applying the ecological framework in parenting plan disputes involves a comprehensive assessment and identification of family violence within the ecological context. Through a systematic approach, we can uncover the multifaceted factors that influence parenting behaviors and outcomes in the context of family violence.

Ontogenetic development (individual-level factors)

At the individual level, parental attributes, mental health, and substance misuse issues can all play a significant role in parenting plan outcomes in family violence cases. Research suggests that parents with a history of using violence against their family members tend to exhibit higher levels of anger or aggression, are more likely to struggle with mental health issues, and have higher rates of post-traumatic stress disorder (Karakurt et al., 2019). O'Leary (this issue) points to the high correlation between alcohol misuse and IPV, highlighting the consequences of substance misuse, such as alcohol or drug addiction, and the impact of substance misuse and IPV on parenting and child maltreatment.

Microsystem (relationship-level factors)

Co-parenting dynamics and parental conflict are important relationship-level factors influencing parenting plan outcomes in family violence cases (Hardesty, this issue). As Hardesty (this issue) noted, high coercive control or power imbalances can significantly impact coparenting dynamics. Protective factors, willingness to engage in therapeutic

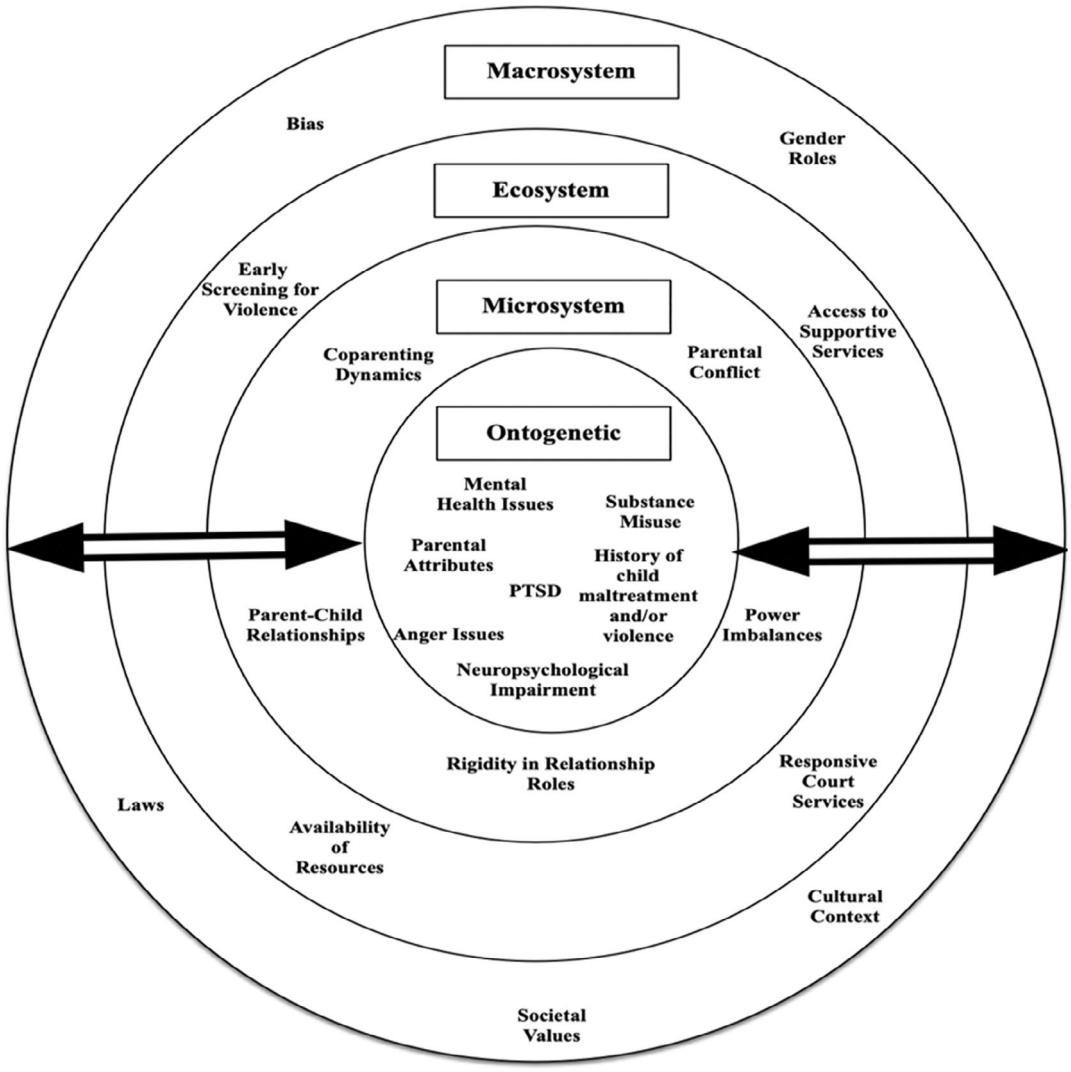

FIGURE 1 The ecology of family violence.

interventions, and demonstrated ability to prioritize the child's well-being can positively influence parenting plan outcomes. Ponting et al. (this issue) have described the potentially devastating consequences of exposure to IPV for young children, affecting the young child's neurological, relational, behavioral and physiological systems.

Exosystem (community-level factors)

Community-level factors, including the availability of resources and support services, also play a role in parenting plan outcomes in family violence cases (Davis et al., this issue). The adequacy of community resources such as shelters, counseling services, and supervised visitation programs, can impact the safety and well-being of parents and children affected by family violence. Davis et al. and Nomura et al. (this issue) describe the efficacy of anti-violence programs for fathers. Fathers can engage in these programs proactively or reactively, focusing on the safety of the mothers and their children and taking accountability through the courts.

Macrosystem (societal-level factors)

The macrosystem refers to societal factors that influence and contribute to family violence. These factors are broad and encompass the cultural, social, economic, legal and political influences within society that can either perpetuate or mitigate family violence, including societal norms and beliefs about gender roles, power dynamics, the responsiveness of the justice system, and the broader political and cultural climate. Davis and Crain (this issue) describe identity abuse in the LGBTQ+ populations as coercive control, capitalizing on societal attitudes towards these communities.

Understanding these factors at various levels within the ecological framework is crucial for professionals involved in parenting plan cases impacted by family violence. It allows for a comprehensive assessment of the complex dynamics at play and informs decision-making processes to ensure the safety and well-being of children in these challenging situations.

CONCLUSION

Exploring the various frameworks and models for understanding family violence has been a valuable exercise for this special issue on family violence and its effects on children, parenting, and co-parenting issues. This process has provided insights into the various dynamics, impacts, and risk factors associated with violence within family settings. This special issue has also offered the opportunity to critically examine the strengths and limitations of the proposed models, approaches, and interventions. Advancing definitional clarity is crucial for addressing the complexities of family violence. Family law practitioners must critically evaluate and redefine existing definitions and frameworks to ensure they capture the breadth of harmful behaviors. This includes recognizing emerging forms of violence, adapting to changes in societal dynamics, and accounting for the unique experiences of marginalized populations.

Definitional clarity should be accompanied by ongoing dialogue and collaboration among family law practitioners and researchers to ensure that definitions are meaningful, relevant, and inclusive. We can enhance our understanding of family violence by critically examining existing frameworks and models, integrating multiple perspectives, and advancing definitional clarity. This approach allows us to address the limitations of current approaches, consider the intersecting factors that contribute to violence, and develop more effective strategies for prevention, intervention, and support. Ultimately, striving for a comprehensive understanding of family violence is crucial for creating safer parenting plans for the parents and children involved in these family law disputes.

Differentiating family violence at the individual level of analysis

By recognizing the need to differentiate and address different types of violence, particularly within the context of parenting, family law practitioners can better promote safety, protection, and healthy parenting practices for the specific individuals involved.

Enhancing training and education for family law professionals

To effectively address family violence in the context of family law disputes, there is a need to enhance the training and education of family law professionals. Providing comprehensive and ongoing training on the dynamics of family violence, the impact of macrosystem variables on the availability of resources for identification and interventions, trauma-informed practices, and the impact on children, including the impact of parent–child contact problems, as well as the effect of family violence on parenting and coparenting can better equip professionals to recognize and respond to these complex cases.

Embracing interdisciplinary perspectives

Family law practitioners (judges, lawyers, mediators, parenting plan evaluators, parenting coordinators, court-involved therapists, etc.) must work together to advance our knowledge of family violence and develop a comprehensive framework for addressing family violence in the family courts. This includes embracing interdisciplinary perspectives, engaging in ongoing dialogue, and prioritizing the safety and empowerment of family members.

Consider evidence-informed approaches for addressing family violence

Addressing family violence requires a comprehensive and evidence-informed approach considering the complex interplay of individual, family and societal factors. Several strategies and approaches have been suggested in this special issue, including the development of resources and tools to address the use of technology for harassment, stalking, and abuse and to enhance digital safety for people who have experienced violence (Davis et al., this issue), the inclusion of screening (Rossi et al., this issue), early intervention (Ponting et al., this issue) and novel treatment approaches to end the escalation of violence (Scott et al., this issue).

IMPLICATIONS FOR PRACTICE AND POLICY

Navigating labels and achieving definitional clarity is essential to understand family violence comprehensively. Through this understanding, we can promote prevention, support survivors and work towards a society free from violence. By recognizing the complexity of violence within family settings and taking action to address it, we can strive towards building safer and more nurturing environments for individuals and families.

Legal interventions are crucial in creating a safe environment for families experiencing various forms of family violence. This may involve implementing protective orders, restraining orders, or parenting plans that prioritize the safety and well-being of the affected individuals, particularly children (Hardesty et al., this issue).

Clinical interventions are equally important in promoting healing and building resilience within the family system (Greenberg et al., 2019). Clinical interventions can provide a supportive and empowering space for individuals affected by family violence to process their experiences, develop coping mechanisms, and strengthen their resilience (Scott et al., this issue).

A collaborative approach between legal and clinical professionals is vital to ensure a comprehensive and coordinated response to family violence in the context of family law disputes. By working together, family law professionals can share information, expertise and resources to develop integrated interventions that address family violence's legal, emotional, and psychological dimensions within a systematic approach that embraces the complete ecology of family violence.

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SPECIAL ISSUE ARTICLE

Parent-child contact problems: Family violence and parental alienating behaviors either/or, neither/nor, both/and, one in the same?

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Abstract

This article argues that in order to intervene effectively and ethically with children who are manifesting Parent–child contact problems (PCCPs) after parental separation, we begin by being mindful of what is normal about divorce transitions and use developmentally appropriate and culturally sensitive analysis to rule out children's common transitory reactions. It is then important to concurrently assess for both family violence (FV) and severe parental alienating behavior (PAB) on the part of both parents, which can co-occur in some cases. The article asserts that it is also important to consider common problematic parenting responses that may potentiate the PCCP but not necessarily rise to the level of abuse. FV is defined as a child's direct experience of physical, sexual, or psychological maltreatment and indirect exposure to sibling abuse and/or to intimate partner violence (IPV). PAB is defined as an ongoing pattern of unwarranted negative messages on the part of one parent that conveys that the child's other parent is disinterested, irrelevant, dangerous, and not to be trusted. Any one or all of these factors may contribute to a child's strident negativity and sustained rejection of one parent, these being defining features of a PCCP. This article proposes ethical principles and priorities for decision-making in these cases, considering the growing social science controversy about assessment and intervention for PCCPs. It concludes with

an analysis of recent, contrasting policy approaches to PCCPs (e.g., Kayden's Law and the Joint Statement of the AFCC and NCJFCJ) and their potential impact on family justice system professionals and the families they serve.

KEYWORDS
domestic violence, intimate partner violence, Kayden's law, parental alienating behaviors, parental alienation, parent–child contact problems

Key points for the family court community

- This article provides more precision in defining Parent–child contact problems, Family Violence, Parental Alienation, and Parental alienating behaviors.
- This article asserts that in addition to forms of violence in families such as sexual and physical abuse and IPV, severe PABs represent a form of FV akin to psychological maltreatment.
- We offer a framework that prioritizes the safety of child and victim parents, with a focus on safety in the face of parental conduct that is damaging, possibly abusive, not protective.
- Two recent public policy approaches to addressing Parent–child contact problems, Kayden's Law and the NCJFCJ/AFCC's joint statement are discussed.

Parent–child contact problems (PCCPs) refer to a spectrum of family dynamics that result in a child developing resistance and sometimes refusal to have contact with one of their parents. PCCPs occur on a continuum of severity, legal and psychological interventions have been developed to attempt to fit the nature and severity of the particular case (Fidler & Bala, 2020, Judge & Deutsch, 2016). Some common reasons for PCCPs developing can include historically limited marginal parental involvement in the child's life, poor parental attunement to the child's needs, and the poor handling of children's normal developmental adjustment to shared parenting arrangements (developmental and attachment issues, dissatisfaction with current parenting arrangements, etc.). Other common reasons include children's response to interparental conflict (aligning with a parent to cope with being caught in the middle of parental conflict), and children's response to severe problems in parenting and coparenting.

PCCPs can be a response to family violence (FV), which is an umbrella term for various kinds of violence that include child abuse, neglect, and intimate partner violence (IPV). Parental alienation (PA) is a type of PCCP where a child, for no adequate or justifiable reason, expresses negative attitudes, beliefs, and behavior toward one of his/her parents primarily due to the preferred parent's denigrating attitudes, beliefs and sabotaging behaviors. A finding of PA should only occur when the dominant single factor contributing to the child's resistance and refusal is a pattern of PABs by the preferred parent.

Multi-factor models of PCCPs assert that, although one factor may dominate its contribution to the PCCP, more typically, PCCPs stem from many, interacting factors that have contributed to the current situation (Drozd & Olesen 2004; Fidler & Bala, 2010; Johnston & Sullivan, 2020; Kelly & Johnston, 2001; Olesen, 2021). Therefore, effective assessment and intervention requires a multi-pronged understanding and approach to the problem that incorporates the entire family system.

PCCPs are increasing in prevalence in the family justice system, particularly in more adversarial processes such as parenting plan evaluations and litigation (Bala et al., 2010; Harman et al., 2022; Lorandos, 2020; Marques et al., 2020). This increasing prevalence is likely the result of several social/cultural and legal movements in the last half century, including advocacy movements to advance awareness and interventions to protect family members impacted by IPV, the father's rights movement and their efforts to advocate for more equal paternal involvement and shared parenting time, and the recognition that children's voices must be meaningfully considered in legal proceedings that impact them (Johnston & Sullivan, 2020). These advocacy movements, each one laudable in their primary intent, have collided in ways that create conflicts between groups. The conflicts have trickled down to social science researchers and practitioners in the family justice system who, in their efforts to understand the issues and support children and families in practice, have unwittingly, replicated conflicting advocacy stances. The tensions and conflict that begin by earnest attempts to redress inequities in the court system get further exacerbated by adversarial court processes, contributing to further polarization as well as actual and/or perceived victimization on all sides. The internet has widened the scope of the problem by way of unvetted sources of information, such as blog sites, personal narratives in the public domain through books, magazines, and social media. Parents have easy access to "unvetted information from unknown, often biased and irresponsible sources" (Johnston & Sullivan, 2020, p. 277). Further, search algorithms operate in ways that give priority to selective information based on the individual user's previous search history. Thus, individuals obtain information from sources that, without their awareness, reinforce their view in a feedback loop, contributing to the polarization evident in the professional context of high conflict parenting disputes. Inflamed by biased perspectives and misinformation, conflicts between parents get supported and heightened, leading to disputes that swirl around the children, increasing the risks of long-term negative sequelae for all family members.

MANY TYPES OF PCCPs

Despite the rapidly expanding research and clinical attention given to one subtype of PCCP, parental alienation (PA) (Lorandos, 2020; Sheehy & Lapierre, 2020), understanding how to differentiate dynamics occurring across the spectrum of distinct but interrelated PCCPs in vulnerable separating families and intervene accordingly is still an elusive enterprise in family law.

In the process of polarization, FV concepts are often pitted against those of PA, vying for endorsement as legitimate social problems. There is a strong social science base regarding the negative, often traumatic, impact of IPV and child maltreatment on children and parents who have experienced these types of Family Violence. The literature on PA phenomena is less robust but developing quickly. For example, Harman et al., 2022 reports a 40% increase in parental alienation research, defined broadly, since 2016. Similar trends have been reported by others (Lorandos, 2020; Marques et al., 2020; Templer et al., 2016). It is well accepted that strategic deployment of PABs manifest as extensions of male-controlling battering in domestic abuse situations with some frequency. Some authors hold that parental denigration of the other parent can be another form of FV, perpetuating ongoing coercive control in the coparental relationship through the children (Harman et al., 2021; Warshak, 2015). Others argue that PA, a specific form of PCCP where one parent consistently and emphatically undermines the child's relationship with the other parent, can be falsely alleged in court proceedings as a counterattack to allegations of Family Violence (Meier et al., 2019; Milchman, 2019). These polarizations mirror the myth that a child who resists or refuses contact with a target parent is either a victim of abuse by that parent or a victim of PABs by the preferred parent, but not

both (Johnston & Sullivan, 2020). Cases are frequently presented in court as false dichotomies in which the child's preferred parent is the alienator or PA perpetrator and the rejected parent is the innocent victim, or the child is resisting or refusing access to a parent because they have been a victim of maltreatment. In fact, the PCCP may derive from a complex interplay of multiple dynamics occurring within the family over time.

The confiscation inherent in definitions of PA juxtaposed against IPV is augmented by the fact that "concept creep"[1] has led to an ever-expanding list of behaviors and attitudes that are included in the definition of PA. As Harman et al. (2022) note, the research literature on PA appears to be less substantial than the volumes of related studies that capture the same phenomena using different terminologies (p. 1890). Allegations of PA are now used to explain false allegations of child abuse or neglect against a rejected parent; to counter evidence of IPV and/or child maltreatment; to label efforts by an abusive ex-partner; to maintain coercive control. It also responds to relocation petitions, parental abduction situations, and over-restrictive gatekeeping of an unfriendly, unsupportive, non-cooperative ex-partner. The lack of clarity is further confounded by the problem that no bright line exists addressing adverse parenting practices between abuse and non-abuse in parenting plan dispute cases in family courts. Despite agreement that a finding of IPV and/or child maltreatment precludes a finding of PA (Fidler et al., 2013), there are no universal criteria to define these distinctions. PA itself is an ambiguous term (Pruett et al., 2023), despite assertions otherwise by PA advocates (Bernet et al., 2010; Harman et al., 2022). Does it mean the parent is the alienator or the child is alienated, either or both? What is the relationship between PABs and PA? Imprecise language in the definition is problematic because it sets up tautologies (the name describes the outcome it is supposed to measure), and the lack of consensus in the field (Pruett et al., 2023) does not allow for the nuanced distinctions that would resolve the problems of ambiguous concept names created.

This article begins with the premise that PA/PABs and Family Violence are real phenomena—and that the scope, prevalence and developmental implications of these phenomena necessitate urgent empirical, clinical and public policy responses. For that to happen productively, the field must come together not in its beliefs, but in its definitions, understanding the relevance of science and differentiation of how these dynamics (individually and in combination) are imperative to assessment and subsequent delineation of appropriate interventions. Implications for assessment, intervention, and public policy will be discussed.

TOWARD A CALCULUS OF ETHICAL PRINCIPLES FOR INTERVENTION IN PCCP CASES

Mounting evidence exposes the developmental risks children face when one parent "shuts down" their relationship with another parent who has not been violent (Harman et al., 2018; Von Boch-Galhau, 2018). Moreover, children (especially very young children) benefit from having relationships with two or more good enough caregivers (Ryan et al., 2019). Apart from the risks to child well-being, the problem of PCCPs raises a myriad of human (civil) rights and ethical issues. The family courts have been accused of institutional gender bias and justice system practitioners of procedural injustice in their attempts to balance the needs, claims, and rights of disputing family members who are also victims of IPV (Meier, 2020). In these matters, accountability and transparency for case disposition follows where a consistent set of ethical principles that guide decision-making can be articulated, especially where relevant facts are ambiguous and social science evidence on the Best Interests of the Child (BIOC) is thin.

Family courts and dependency (juvenile) courts share several priorities in addressing IPV, child maltreatment, and PA cases pertaining to children (Johnston, 2016). First and foremost is to protect the child from abuse and violence. Second is to secure the child's relationship with at least one parent who offers emotional security and physical protection. This is enabled by protecting the denigrated parent's or victim's parent's security and autonomy to care

[1]First described by Haslam (2016), concept creep refers to the expansion of a set of harm-related concepts over time. Semantic inflation results in the inclusion of an increasingly wide range of phenomena referring to one concept (also see Haslam et al., 2021). The "creep" often is motivated by political actors (Sunstein, 2018) wanting to strengthen their advocacy position by broadening the sense of its breadth and influence.

for the child. The third priority is to promote and protect the child's involvement with and access to both parents, assuming safety and security are in place (Johnston, 2016). Moreover, the courts in democratic societies must proceed to maintain the freedom and civil rights of all individuals, including children, from undue, unwarranted, or disproportionate state interference. A child-centered approach (BIOC) involves never relinquishing the first and primary priority. The second and third priorities are revisited when safety is achieved, with the goal of achieving parental inclusivity once safety and security are established or court orders and/or interventions are in place to support and monitor progress toward rehabilitation and repair. This hierarchy of child protection is impossible to achieve if practitioners and professionals are confused about the definitions and meanings of the terms and dynamics under consideration: yet recent research suggests that this is precisely the situation.

In a large study of family court professionals, the current authors found that among 1049 experienced family law professionals, respondents were evenly split in their belief that they understand the difference between PA-related terms (Pruett et al., 2023). Their consensus was that PA is a valid phenomenon with PABs a common occurrence. Demonstrating the endorsement of conflicting beliefs, PA was understood to co-occur with other types of Family Violence yet there was no consensus, and over half of respondents were undeclared about whether PA more often co-occurs in parenting plan dispute cases alleging IPV. In all, a third of respondents believe that PA is a flawed concept, and as an example of the confusion in the field, nearly half endorsed that PA can occur without the central defining feature of the concept (i.e., a parent who intentionally alienates a child from the other parent). The data indicated confusion about the role of this single dominant construct. Even with the current amount of writing and research about PA concepts, unfortunately there no prevalence data on what is a common PCCP case where a dominant single factor of IPV, child maltreatment, or PA is alleged and not found, so that ultimately other factors are contributing to the PCCP.

THE SINGLE-FACTOR PA THEORY

The dominant or single-factor version of PA arguments (Johnston & Sullivan, 2020; Joyce, 2019) offer a deceptively simple explanation and legal remedy: a child's unwarranted negative attitudes and behavior toward a target parent, with whom they had a previously good relationship, are primarily due to the PABs of the preferred parent. The *cause* (A) is systematic programming by a favored parent; the *effect* (B) is manifestations of programming in the child, and the *remedy* (C) in severe situations is change of parenting time to the target parent and isolating the child from the preferred parent. This transfer was reported as being "very effective" in "severe" cases of PA (Harman et al., 2022, Warshak, 2010), as were orders for the child to spend more time with the rejected parent (Warshak, 2019). However, the single-factor theory assumes that child abuse and IPV have been ruled out, as have alternative explanations for PCCPs. Yet clinical experiences reveal that PA and FV dynamics often exist in tandem, and court evaluations are rife with clinicians trying to separate the contributing factors to recommend interventions. In addition, many PCCP cases have no evidence of either FV or PA/PABs (even though one or both may be alleged). Clearly, the A-B-C theory does not adequately account for context, as does the multi-systemic theory below. Moreover, research is lacking that contains clear definitions of PA/PABs, showing there are not clear distinctions between the concepts and their concomitant behaviors and outcomes.

Problems arise when practitioners and legal professionals overstate the social science evidence under pressure of scholar advocacy for decisions, assume a deterministic rather than a probabilistic relationship among the variables contributing to A and B above, confuse association with causation, and confuse ideology with scientifically derived evidence. If this confusion is influencing the field, then we cannot expect better outcomes for the children and families with whom we are working clinically or legally.

THE MULTIPLE-FACTOR PCCP THEORY

The literature on PCCPs provide several multi-factor, system-based models that identify the complex interplay of many factors within individual family members (personality vulnerability in parents, child temperament, age),

between family members (interparental conflict, pathological parent–child attachment), extended family influences (grandparents, new relationships), and factors external to the family (involvement by mental health professionals, court, or social service agencies) that can contribute to PCCPs (Kelly & Johnston, 2001; Johnston & Sullivan, 2020). These models caution family justice professionals against making prior assumptions about any singular or dominant "cause" of a child's rejection of a parent in any case. This is particularly when other specified factors are present and rather encourage an approach to these cases that systematically assesses all factors that contributed to the current family dynamics to effectively intervene in any particular case. Drozd et al. (2020), for instance, suggest a decision tree that includes consideration of normal developmental affinities for one parent over another at various ages and stages, responses to abuse (child, IPV, parent substance abuse), child vulnerabilities stemming from childhood experiences or problems, and parenting difficulties such as behaviors toward the child that are too rigid or lax, overinvolved and intrusive, mis-attuned, or denigrating of the other parent. Fidler & Ward (2016) describes factors that differentiate characteristics and severity of the PCCPs, and models for gathering and analyzing information garnered about a particular family in a structured and consistent manner. Another approach posits four primary factors that predict outcomes in treatment (Johnston & Sullivan, 2020).

According to this multi-factor theory, an array of developmental and problematic factors can combine to create an alliance with one parent against the other. PABs by the preferred parent is an important but not necessarily the dominant factor accounting for PCCPs characterized by children's resistance or refusal of contact with a parent following parental separation. The context of behaviors and emotions of all family members include influences on children's negative stance toward one parent deriving from child, parent, coparent, parent–child, sibling, and multigeneration (e.g., grandparent) characteristics.

Even in the more prevalent types of PCCP situations, for example where a child's response to IPV or parenting problems, including maltreatment, is the dominant factor in a child's resistance to contact with a parent compared to the less prevalent situation where the PABs by the favored parent is the dominant single factor in a child's resistance to a parent, approaching cases with an "anchoring bias" is likely to lead to errors in accurately identifying critical case dynamics. An anchoring bias is an assumption or bias that we generate as our first impression of a case. It's our initial "take" and sets up the likelihood of another common cognitive bias, confirmatory bias, where we selectively collect and evaluate information to confirm the initial bias (Simon & Stahl, 2014). Anchoring biases may dominate for a variety of reasons, including but not limited to insufficient professional training in assessment of all topics related to PCCP cases, professional practices that have a specific emphasis (particularly IPV and PA), personal experiences that impact views, media information sources that are biased, and an ongoing predominant association with advocacy positions or groups. This latter example is known as the "echo-chamber phenomenon".[2] By participating in an echo chamber, people are exposed solely to information that reinforces their existing views without encountering opposing views, potentially resulting in an unintended exercise in confirmation bias. Echo chambers may entrench social advocacy positions and extremism, which trickle down to all of our social institutions, including the family justice system.

Preventing these source biases can be helped by assuming a multifactor approach to data collection and analysis with four recommendations: (a) approaching each case individually and testing multiple hypotheses while collecting information and considering both confirming and disconfirming data; (b) using structured protocols and checklists for screening and assessment (e.g., B-SAFER for IPV – Storey et al., 2014; Kebbell, 2019; Decision Making Trees for Parenting Plans and Custody Evaluations—Drozd et al., 2013; structured data collection for PCCPs—Fidler & Ward, 2016); (c) training in all areas of study relevant to PCCPs, especially those areas of subspecialty with which the professional is less familiar; and (d) engaging with professionals from other specialties that emphasize or advocate positions in the field.

[2]"… an echo chamber refers to situations in which beliefs are amplified or reinforced by communication and repetition inside a closed system and insulated from rebuttal". Echo chambers limit exposure to diverse perspectives, and reinforce presupposed narratives and ideologies. https://en.wikipedia.org/wiki/Echo_chamber_(media)#:~:text=In%20news%20media%20and%20social,system%20and%20insulated%20from%20rebuttal.

In clinical roles, professional guidelines offer considerations for best practices, such as the Guidelines for Court Involved Therapy created by a Task Force of the Association of Family and Conciliation Courts (AFCC, 2009) and (also see the white paper article regarding the Guidelines by Fidnick et al., 2011). The Guidelines enumerate best practices that include assessing levels of court involvement, identifying professional responsibilities, maintaining advanced training and competency levels, avoiding multiple relationships that could represent a conflict of interest, making clear fee arrangements, obtaining informed consent, maintaining privacy, confidentiality and privilege, following recommended procedures and methods, keeping appropriate documentation, and paying attention to what is communicated to whom in a case. These guidelines attempt to support professionals acting in a child's best interests at the highest level of professional responsibility, that focuses on holding multiple hypotheses and engaging in procedures that are comprehensive, balanced, fair, and sensitive to ethical dilemmas rife in psycho-legal work.

CONCEPTUAL DISTINCTIONS BETWEEN PCCPS, PA, IPV AND CHILD MALTREATMENT

We have argued that PCCPs include a complex spectrum of issues that can result in a child developing resistance and refusal to have contact with a parent. PCCPs are not equivalent to PA, IPV, or child maltreatment. In fact, from our clinical experience, cases where a dominant single factor drives a PCCP, such as FV or PA, are not as prevalent nor as challenging to address as are cases where multiple factors contribute to the problem. Even more challenging and quite common are the PCCP cases where neither FV nor PA are "found," and there is a mandate (by agreement of the parents or the court) to address the PCCP by working to reconnect the rejected parent and child. In these cases, children resist and refuse contact with a parent without an abuse-related reason, yet behave and express negative opinions adamantly and often vehemently. Whereas both parents can be assessed to support the child's relationship with the rejected parent, the child's well-being is pitted against the rejected parent's desire for a relationship, eliciting angst among all members of the family triad and professionals involved.

WHY THESE DISTINCTIONS MATTER

While debates about definitions and appropriate interventions swirl within scholarly circles, (Bernet et al., 2010; Meier et al., 2019; Milchman et al., 2020; Nielsen, 2018; Warshak, 2020; Harman et al., 2022, Fidler & Bala, 2020, Hardesty and Ogolsky, 2020) in the trenches of the family courts and with professionals who work in these complex, real-world cases, the impact of poorly managed increasingly intractable PCCPs on children are experienced in our daily work. Cases presenting with child maltreatment, intimate partner violence and parental alienation all create challenges, risk, and complexity to understanding and intervening in the case. Lost in these debates is that many types of PCCPs can contribute to extremely adverse child developmental impacts. A wrong decision can result in a child's loss of bonds to one or both parents (Warshak, 2019). Waiting too long to figure out what is happening in the family can lead to entrenchment of the child's avoidance of the rejected parent. Multi-generational consequences may include loss of extended kin relationships. At the severe end of the risk continuum, safety risks such as a child living in the exclusive care of a disturbed or abusive parent or death, highlight the ultimate potential risk to children in these cases (Meier et al., 2019). Also tragic are "parentectomy" outcomes where a parent and their side of the family are expunged from a child's life by the ongoing campaign of PABs perpetrated by another parent (Baker, 2005).

With so much at stake, it is imperative to maximize concept precision, accurate assessment, and treatment planning as early in the identification of PCCPs as possible. The likelihood of these pernicious outcomes is minimized when professionals correctly understand and assess the problem while recommending appropriate treatments. With overlapping characteristics in subtypes of PCCPs, the risk of assessment errors are high when referring a family for

PA intervention without recognizing that restrictive gatekeeping behaviors (Austin et al., 2013) can serve as the protective basis for one parent cutting off another from a child, and can risk doing further damage to the family. Similarly, in some cases, missing one parent's controlling and coercive behaviors that damage or severe a child's relationship with an adequate parent has damaging consequences that are very difficult to mend.

PARENTAL ALIENATION

We have asserted above that the definition of PA is often missing the context central to the concept. PA is used to refer to the alienating behavior of the parent, the characteristics of an alienated child, and a theory of how alienation occurs. PA refers to family situations where a child, for no adequate or justifiable reason, expresses negative attitudes, beliefs, and behavior toward one of his/her parents primarily due to the preferred parent's denigrating attitudes, beliefs and sabotaging behaviors (Baker, 2005; Bernet et al., 2010; Gardner, 2002). We argue that PA is a type of PCCP where the dominant single factor contributing to the child's resistance and refusal is a pattern of PABs by the preferred parent. When the PCCP has multiple contributions, these cases are not PA cases; they are another type of PCCP case. Similarly, child estrangement is a type of PCCP, where the dominant single factor contributing to the child's resistance and refusal to have contact with a parent is a response to the rejected parent's behaviors (past or current). These can be child maltreatment, intimate partner violence, or deficient parenting practices, including PABs by the rejected parent.

What are parental alienating behaviors (PABs)?

PABs are defined as "an ongoing pattern of observable negative attitudes, beliefs and behaviors of one parent (or agent) that denigrate, demean, vilify, malign, ridicule, or dismiss the child's other parent … together with the relative absence of observable positive attitudes and behaviors, (affirming the other parent's love/concern for the child, and the potential to develop and maintain the child's safe, supportive and affectionate relationship with the other parent)" (Johnston & Sullivan, 2020, p. 283). Harman et al. (2018) further state that PABs are not discrete events, they are enacted over time and alongside other behaviors with the intent of hurting, damaging or destroying the child's relationship with that parental figure and/or that parental figure themselves.

PABs are observable behaviors by parents that can contribute to a child's emotional distancing or rejection of one or both parents. For example, in some cases, PABs have a damaging impact on the child's relationship with both parents (Rowen & Emery, 2019). In higher conflict shared parenting arrangements or in cases where the child has more of an alliance with one parent (stronger attachment, more dependency, more parenting time, etc.), the impact of parents who engage in PABs typically have a differential effect on the other parent–child relationship, creating an "unholy alliance" (Johnston et al., 2009). This further reinforces the child's negative view and rejection of the parent with whom the child is not aligned. Professionals in family law consider PABs to be emotionally damaging to a child (Pruett et al., 2023), which when severe, are a form of child maltreatment and FV characterized by coercive control (Von Boch Galhau, 2018; Harman, et.al., 2018; Harman, et al. 2020; Milchman et al., 2020).

WHAT IS FAMILY VIOLENCE (FV)?

In this article, we define Family Violence as child maltreatment (physical, sexual, emotional) and intimate partner violence (IPV) which has traumatic impact on the domestic partner and on the child both through direct and indirect exposure (AFCC Guidelines for Examining IPV, 2016; also see the Battered Women's Justice Project, https://bwjp.org). We further assert that in addition to these forms of violence, severe PABs occurring in parenting plan dispute

cases, is a form of FV akin to psychological maltreatment. The American Professional Society on the Abuse of Children (APSAC) defines psychological maltreatment as "a repeated pattern or extreme incident(s) of caretaker behavior that thwart the child's basic psychological needs (e.g., safety, socialization, emotional and social support, cognitive stimulation, and respect) and convey a child is worthless, defective, damaged goods, unloved, unwanted, endangered, primarily useful in meeting another's needs, and/or expendable" (APSAC, 2019). Legal definitions vary across states and may include both indicators of the perpetrator's behavior and the effects on the child, more often focusing on the child's outcomes.

Six subtypes of psychological maltreatment are identified, with the one most relevant to the present paper being *Exploiting/Corrupting*. This describes caregiver acts that encourage the child to develop inappropriate behaviors and attitudes (i.e., self-destructive, antisocial, criminal, deviant, or other maladaptive behaviors). Among others, these acts are characterized as modeling, permitting, or encouraging betrayal or being cruel to another person. These acts also subject the child to belittling, degrading, and rejecting treatment of parents, siblings, and extended kin, coercing the child's submission through extreme over-involvement, intrusiveness, or dominance, and manipulating or micromanaging the child's life (e.g., inducing guilt, fostering anxiety, threatening withdrawal of love, placing a child in a double bind in which the child is doomed to fail or disappoint, or disorienting the child by stating something is true/false when it patently is not). The acts may contain emotional unresponsiveness (ignoring) and *Isolating*, with the latter being caregiver acts that consistently and unreasonably deny the child opportunities to meet needs for interacting/communicating with peers or adults inside or outside the home (APSAC, 2019).

In accord with our own assertions, APSAC's definition suggests that severe PABs reach the level of child maltreatment. The pattern of regular denigration aimed at controlling the child's access to the other adequate parent and negatively impacting their affection for that parent exploits and corrupts that parent–child's relationship. Such parental behaviors are detrimental to the welfare of children. The implication of a child's rejection of a parent in response to PABs from the other parent are without basis for physical and psychological protection and are maladaptive. This must be handled by courts and practitioners as a situation of abuse.

What is the distinction between other subtypes of FV and PABs?

As noted, PABs are problematic and harmful to children because they promote enmeshment or other problematic parenting behavior but may or may not rise to the level of child maltreatment. These behaviors deprive children of positive parenting and create conditions in which children's sense of security to both parents is undermined. Children having two (or more) secure relationships to parents is more favorable than having one or none (Sagi & Van IJzendoorn, 1996; Lamb, 2021). Moreover, when parents are in conflict and adolescents feel caught between them, they are less likely to feel close to both parents, which is associated with poor adjustment (Buchanan et al., 1991). In this way, extreme patterns of PABs are part and parcel of child maltreatment. These PABs constitute a form of coercive control perpetrated against the other parent through the coparenting relationship. For example, false allegations of FV (IPV, child maltreatment and PAB's) can create turmoil and trauma in the family and contribute to the temporary disruption or permanent loss of an adequate parent. They are also a form of coercive control because they exploit the child as a tool of the perpetrator against their other parent (Harman, et al. 2018; Drew, 2022). But sometimes the false, distorted allegations against a co-parent are evoked by paranoid beliefs or delusions that the parent cannot separate from reality; more often than not, the child cannot separate them either. The damaging outcome calls into question whether a conscious, malicious motivation is a necessary condition of perpetrating FV in all its forms. The parent's behavior must be considered as an issue of abuse regardless of intent, so that outcome/impact is given precedence over intent.

Whether PABs reach the level to constitute FV depends not only on intent, but on severity and context. Not all parental behaviors that resemble PABs are indicative of FV and some can be protective of a child and a preferred parent (Milchman, 2021). However, PABs can be part of a coercive and controlling pattern with a co-parent and/or

coincide psychological maltreatment of a child. The problem exists most powerfully in the gray zone where no dominant single factor for the child's rejection of a parent is assessed. There are no clear demarcations about when the kinds of damaging parenting behaviors inherent in high conflict divorce or separations among psychologically vulnerable parents are frequent enough, severe enough, or impactful enough that the behaviors become a pattern that slips into the red zone of PA, IPV and child maltreatment. These are the cases in which controversy festers and reproduces time and again in the family courts.

CLINICAL IMPLICATIONS FOR ASSESSMENT AND INTERVENTIONS IN PCCP CASES

Differential assessment

Adding to the challenges and controversies of asserting that PABs can be a form of FV, parental behaviors alleged to be PABs can be protective of a child (Milchman, 2022). That is, the same observable parental behaviors, such as not supporting contact with the other parent, can have different intent and impact depending on the familial context in which they occur. The extreme examples of a parent filing a restraining order or making a report of child abuse exemplifies this issue. These actions can be appropriate and necessary on the part of a parent to protect themselves and their child from FV. That same action, particularly if malicious, can have a devastating impact on the other parent's contact and relationship with their child. In fact, the intent of the parent's action may be protective or well-meaning rather than malicious and coercively controlling, but such protection can be damaging. Take, for example, the parent who misinterprets the behavior of the other parent as dangerous or abusive due to residue of their own past trauma experience or the child's distorted reports of their experience with the other parent, what happens when that parent takes action with the court based on these distortions? With the child initiating or supporting the views of the parent engaging in that behavior, a determination that the behavior constitutes PABs is more challenging to prove. Family court professionals are faced with determining these crucial distinctions in cases where a PCCP is present, but its genesis is unclear. The possible mis-assessment of what type of PCCP is occurring puts the child's welfare at risk and complicates efforts of professional help working in the family courts, thus, increasing professional risk and exacerbating the conflict. (Warshak, 2020).

An additional challenge of differentiating PABs from protective parenting behaviors is that the child's voice, which is critical to the determination of their best interests, is typically aligned with the views of the parent alleging IPV or child maltreatment by the other parent. In these cases, it is our experience that the child's voice can have a biasing impact on child protective service involvement that favors a finding of those forms of FV. Finally, child protective service investigations typically make findings of whether abuse/neglect have occurred and rarely address false allegations as PABs that are emotionally/psychologically abusive to a child. This investigative bias can result in the greater likelihood of multiple false allegations by a parent and/or "forum shopping" as they receive no negative consequences for that psychological maltreatment of the child.

An encouraging approach that assists the differential assessment of parenting behaviors that contribute to PCCPs has been provided by Madelyn Milchman (2022). The author's protocol assists in the clinical and forensic assessment of the causes of parental rejection in parenting plan dispute cases. The Multidimensional Assessment of Causes of Parent Rejection (MAP) provides a schema to assist the interpretation of data collection to help differentiate protective parenting behaviors and PABs (Milchman, 2021). The MAP model lists behaviors that have been identified as PABs in the social science literature, asking the question, "What else could cause a parent to engage in that behavior?" It encourages a deeper investigation of parental behaviors that can help discern whether a particular behavior, such as contact interference, bad mouthing, or allegations of FV by a parent are PABs or protective parental behaviors. Similarly, it encourages an investigation to interpret whether child behaviors in a specific case, (such as making allegations of abuse, providing frivolous reasons or borrowed scenarios to justify their rejection of a parent),

show complete lack of ambivalence in their negative views of a rejected parent. Further, does the child ally with the preferred parent, or respond in a disproportionately rejective way? Is the child's behavior consistent with an abuse-related response, influenced by PABs, or in response to other factors impacting the child within or outside the family system? The MAP protocol has the benefit of providing assessment guidance for each potential cause of a PCCP, it organizes them sequentially, incorporates external evidence, and makes a review of the expert's evidence more transparent by requiring the weighing of corroborating and disconfirming evidence. This assumption supports a sequential approach to assessment in PCCP cases where IPV and child maltreatment is distinguished and prioritized over PABs in all cases. That anchoring bias does not acknowledge that in some cases, PABs can be extremely harmful and traumatic to children and abusive to the perpetrator's coparent, so individual case analysis of the presence, severity, and impact of PABs (which are by definition not protective), must be integrated into an analysis, even as safety is prioritized in assessment.

A challenge in the differential assessment of PCCPs of all types, particularly where none of the forms of FV (IPV, child maltreatment and PABs) are found, determines the presence and severity of multiple factors within and outside the family system that are contributing to PCCPs. For instance, even if non-abusive, adverse parenting practices on either or both parents' part, can be harmful to children and promote resistance to contact with a parent, thus contributing to PCCPs. The determination of their severity and impact is critical to designing appropriate interventions. Some current models provide useful differentiation of aspects of family system dynamics that are relevant to assessing the severity of the PCCP and the vital importance of maintaining a "safety first" stance throughout assessment and intervention (Johnston, 2016). These assist in determinations of prognosis and implementation of appropriate legal and psychological interventions.

Measurable aspects of individual behavior (parent and child), relationship patterns (parent–child, coparenting) along with other factors internal to the family system (the health/pathology of family narratives, extended family involvement, etc.) and external to the family (adversarial court involvement, the quality and effectiveness of clinical interventions), are identified in systematic assessment models by several authors (Judge & Deutsch, 2016; Fidler & Ward, 2016; Johnston & Sullivan, 2020; Drozd et al., 2013). These multi-factor models can make the assessment of PCCPs more accurate, which can help legal and psychological interventions better fit the subtype identified (Walters & Friedlander, 2016). Drozd and colleagues have provided a stepwise sequential approach to decision-making about PCCP, which puts child and parent safety first. This guards against anchoring biases in cases that are multi-determined. Moreover, it assists with the sequencing of interventions and highlights ongoing review of the focus of goals and objectives of interventions and its effectiveness (Drozd et al., 2022).

Clinical interventions

Some IPV advocates assert that even interventions that address the subtypes of PCCPs where IPV is not the dominant factor should not be undertaken (e.g., Mercer, 2021). They make the argument that these interventions lack any scientific support of safety and effectiveness necessary to intervene responsibly and ethically. We believe that this stance is flawed for a number of reasons. First, a standard that places a threshold for clinical intervention that requires evidence-based treatment and has randomized controlled trials (RTC) of specific intervention protocols with rigorously identified samples of patients that measure safety and effectiveness before they can be employed, is an unattainable standard for virtually all existing court-involved interventions (Boaz & Davies, 2019; Greenberg et al., 2019; Pruett et al., 2021, Drozd, et.al., 2022). If this standard was applied to interventions addressing the spectrum of PCCP cases, none, including those that are currently employed to cases of IPV, would meet those standards. Further, applying this standard would preclude the development and use of interventions in social science that are already accepted in our field but have not previously been applied to family court situations. These legal and clinical interventions are usually supported by evidence-based practices from other areas of practice that are then applied to the family law population. They are "evidence-informed" treatments.

While the interventions are not evidence-based for this new application, it is a step in the right direction for learning which of them are effective with family court populations. Greenberg et al. quote that the American Psychological Association definition of evidence-based practice (APA, 2021) is "the integration of the best available research with clinical expertise in the context of patient characteristics, culture and preferences." This science-informed standard is the standard of practice for most, if not all, roles and interventions in the family justice system (Greenberg et al. 2019; Greenberg et al., 2021), including court-involved therapy, co-parenting counseling, parenting coordination, parenting plan evaluation, mediation and interventions with court-involved populations that present with trauma, interparental conflict, special needs children, substance misuse issues and FV. Though caution is prudent, including a rigorous risk/benefit analysis of intervening, prohibiting interventions for a large and vulnerable population because no evidence-base is yet established, is to make "the perfect" enemy of the good.

The development of clinical interventions specifically designed to address the spectrum of PCCPs is no exception to this common trajectory. They apply a variety of existing evidence-informed treatments, including interventions that are psychoeducational (Moran, et.al, 2019), trauma-informed (Deutsch et al., 2020), culturally informed (Harris-Britt, et al., 2021) coping or skills-based approaches such as family systems (Lebow& Reckart, 2007; Greenberg & Lebow, 2016; Faust, 2018), and child-centered conjoint therapy (Greenberg et.al, 2016).

Given the limitations and realities of research on legal and psychological interventions in the family justice system in general, responsible interventions for PCCPs should be tailored to fit proportionately to the severity and type of case. For example, unless the PABs are both determined not to be protective of the child and to have the severity of child abuse and psychological maltreatment, removing the child from the favored parent's care is not a proportionate response. Neither is intervening to protect the child in this situation as emotional harm is occurring, in which case a proportionate response at least initially, should be an evidence-informed family systems intervention (Judge & Deutsch, 2016; Walters & Friedlander, 2016).

A family-systems, strengths-based treatment model responds to the primary mission of family courts creating parenting plans that include both parents, but only after ensuring both physical protection and emotional security are in place for the child and at least one parent who can keep the child safe and secure. In fact, with the "Best Interests" of the child as the objective, principled decision-making involves pursuing four priorities in sequence: (1) protection of the child from harm, (2) security of the child's relationship with a non-offending parent, and (3) accountability and reparation of any violation of the child's lived-experience by an offending parent(s), before attempting (4) inclusion, that is reconciliation and reunification of the child with an offending parent.

There are controversies that inevitably arise from this task, as critiques of the approach assert that particular interventions cannot rely on a sufficient evidence-base to support the verification of successful practice. Yet, Johnston (2016), in reviewing the Overcoming Barriers treatment approach to situations where a child strongly and persistently resists or refused contact with one parent for little or no substantial reason states, "the approach draws upon the collective experience of well-seasoned clinicians and is informed by a wide range of research evidence and appears to be relevant to understanding and treating these kinds of problems" (p. 307). This is consistent with science-informed practice. We believe that careful analysis and grounding in evidence-based literature argues for cautious but forward movement, since "doing nothing" is usually too costly for children and families in need of immediate treatment.

Public policy implications

Two recent public policy approaches to the controversies in the family justice system as it struggles to address the challenges and complexity of PCCP cases are compared in this section. One is Kayden's Law (2022), which was a specific add-on language to the Federal omnibus funding bill called the Violence against Women Act (VAWA) of 2022. Kayden's Law prohibits funding associated with the bill for states that acknowledge Parental Alienation as part of the spectrum of types of PCCP. It is based on flawed premises which appear to originate largely from one

preliminary and controversial study (Meier, 2020; Harman & Lorandos 2021; Meier, et al. 2022) and a successful last-minute lobbying effort by a singularly focused advocacy group in Congress just prior to the bill's passage.

There are several problematic impacts of the bill's potential adoption at the state level. First, interventions that seek to address any other subtype of PCCP than those where IPV is present are precluded. The legislation further proposes that judges be prohibited from using their discretion of court-based interventions that have a goal of reunification to a rejected parent where domestic violence has been found to have been perpetrated by that parent at any time. It does not take into consideration the severity of the abuse, the impact of the abuse (precludes a trauma-informed approach), current or future safety issues, any relevant factors in the child's experience in the custodial parent's home (adverse parenting, mental health/substance misuse issues, attachment issues, etc.), and any meaningful positive changes in the abusive parent that may have occurred over time – perhaps as a result of effective treatment. Most concerning is that Kayden's Law mandates for federal funding of programs at the state level appear to extend to all child custody cases where PCCPs are present, not just those where domestic abuse is present. This ignores the huge variety and severity of cases, and contributing factors that we have detailed throughout this article.

Second, training in any topic areas relevant to PCCP other than domestic abuse is not permitted if states want funding. Not surprisingly, PABs are not acknowledged as a possible form of FV, and training in our current understanding of PA as a type of PCCP is mandated not to be included. Third, discretion of judges is limited in PCCP cases to both restrict the existing parenting time for the preferred parent, and to order interventions that address the problems in the family system. For all of these reasons, it is our view that if adopted by states, Kayden's Law will have an adverse effect—not just on cases of PA—but on all cases where families need legal or clinical interventions to address the broad range of PCCP types described in this article.

Another public policy approach was recently published in a joint statement by the Association of Family and Conciliation Courts (AFCC) and the National Council of Juvenile and Family Court Judges (NCJFCJ) (AFCC & NCJFCJ, 2022). In contrast to Kayden's Law, the statement was authored by a joint organization, multi-disciplinary task force, who took two years to finalize the statement. It was informed by a survey of 1049 members of both organizations (Pruett et al. 2023), integrated the available social science on PCCPs, and formally approved by the membership of both organizations.

The NCJFCJ/AFCC joint statement identifies some central problems in the family justice system's efforts to address PCCPs as hampered by "gendered and politicized assumptions that either parental alienation or intimate partner violence is the determinative issue" and "a lack of understanding of different perspectives, education among family law professionals and resources" (p. 1). It provides the following considerations and recommendations to family court professionals that are in contrast to the mandates of Kayden's Law and consistent with the points of this article:

1. In terms of prioritizing the safety of children and parents, "A paramount focus of practitioners working with parent-child contact problems should be to promote safety, interests, rights and well-being of children and their parents/caregivers at all socio-economic levels" Addressing the priority of safety: "Parent child contact issues, once identified, should be uniquely screened for safety and family risk factors, including the severity, frequency and impact". The risk factors identified include PABs.
2. Addressing screening and assessment in PCCP cases, the statement supports the consideration of all factors that may contribute to PCCPs, and it includes PABs in safety assessment and in professional training to effectively work with families where a PCCP exists. It notes the limitations of relying on social science in the complexities of real-world practice and stresses the importance of examining each case uniquely, to intervene in an effective, child-focused manner.
3. With regard to interventions, the statement supports when referring, recommending or ordering services and interventions for PCCP cases, that they should be proportionate, accessible and accountable.

4. Relevant to professional training, the statement includes PA in a comprehensive list of topic areas relevant to increase the competence and specialized knowledge necessary to work with PCCPs.

CONCLUSION

As if PCCPs were not complicated enough to assess and treat, the lack of conceptual clarity within the field about their subtypes is a significant problem that hinders more effective progress being made to help families facing these painful, often intractable dynamics, with devastating consequences. Since concepts are tools to guide understanding and treatment, increasing their precision is critical to their utility. This article provides greater precision in the distinctions and overlaps between subtypes of FV (IPV, child maltreatment and PA/PABs).

A multi-factor approach to assessment that guards against anchoring biases is essential to the differential diagnosis of subtypes of PCCP. This concept development can help prevent the weaponization of these concepts that frequently occurs in the legal adversarial court contexts that address these issues. We believe it will deter the concept creep that blurs distinctions so that concepts can be argued to be true and false, especially because their definitions become so broad that exceptions and variations are easily identified in every circumstance.

The data is clear: PCCPs are prevalent, harmful to children, and vexing to the family justice system. A differential assessment is critical to designing and implementing proportionate, effective legal and psychological interventions in these complex cases. If PABs are severe, they, like other forms of harmful parenting behaviors, are psychologically abusive to children and can be coercive and controlling to the rejected parent. Therefore, efforts to better differentiate parental behaviors that are alienating or protective like those described in this article are critical.

This article focuses on the definitional clarity needed to support the development of appropriate assessment and effective intervention even when complex dynamics threaten to obscure the clarity sought. Professional understanding of the overlaps and distinctions between PABs, PA, IPV, child maltreatment needs to be augmented. Public policy support of research, practice, and training on all types of PCCPs, best serve the interest of children and families in the family justice system.

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SPECIAL FEATURE

Conclusion: Mental health and legal responses to the adolescent mental health crisis: Raising the bar on best interests and promoting family connectedness in divorcing families

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Abstract

We are currently facing an unprecedented increase in adolescent mental health problems resulting in alarmingly high levels of depression, anxiety, and suicidality. Significant mental health problems among youth pose unique challenges to families in the process of separation and divorce, as well as to family law professionals across all disciplines. The current adolescent mental health crisis calls for new ways of approaching our work with high conflict families to promote family connectedness and shift away from adversarial approaches that may exacerbate conflict and further destabilize families. As a conclusion to the special issue on adolescent mental health needs, the authors make multidisciplinary best practices recommendations and advocate for systems level changes in recognition of the needs of youth in crisis at this pivotal developmental stage.

KEYWORDS
adolescent, best practices, family law, high conflict, mental health

Key points for the family court community

- Mental heath crises among adolescents and families require newer and advanced education regarding adolescent mental health for legal and mental health professionals.

- Current mental health issues among adolescents complicate family court responses and sometimes deflect from the family systems problems.
- The current crisis calls for an increased focus on careful assessment and conflict resolution in all professional roles.
- Professinals also must reach beyond coparenting conflict to assist with the family's commitment to retaining connection through the process of divorce and beyond.
- Conflict-reduction can be better supported by an equal focus on building positive coping skills, attitudes and strategies.
- Needed shifts in intervention require training in interdisciplinary teams, using case examples to foster collaborative skills.
- We recommend redefining the roles of mental health professionals so they are bounded, explicit, and supportive of family autonomy, with reduced susceptibility to being coopted into the adversarial divorce system.

INTRODUCTION

This special section took a turn from the usual scholarly directions of FCR to focus explicitly on legal and mental health professionals' perspectives of the mental health crises facing today's youth. The section editors, Dr. Amy Wilson and Dr. Marsha Kline Pruett, proposed to identify key issues and explore barriers and everyday practices with youth and their families from perspectives of various roles in family law, with the intention of inspiring workshops, research, and interventions that respond to this unusual crisis point in societal history, and by default, in family law. While depression and anxiety are the most recognizable mental health problems we face, the authors in this section identified issues that move beyond depression and anxiety, adding important detail to the general mental health problems discussed in lay literature and scholarship. These commentaries and articles provide a clearer picture of what professionals of all disciplines need to watch for, assess, and help families manage on their own or through therapeutic resources and family law interventions. They also suggest promising practices that offer hope and practical suggestions for professionals working with these youth in great pain, and their families.

PROFESSIONAL PERSPECTIVES AND RECOMMENDATIONS

Professional perspectives regarding the youth mental health crisis reveal diversity across roles, yet consistency in terms of shared concerns. **Pasternak and Montgomery**, **Ajoku**, and **Mitnick** share their "reports from the front lines" in the roles of therapist, parenting plan evaluator, and parenting coordinator. The challenges they articulate include sharply increased suicidality among teens, difficulty obtaining mental health services for their clients, and

the need for validated assessment and evaluation techniques in response to increased complexity and fragility in the family system, exacerbation of high–conflict struggles that manifest -for example- in parent–child contact problems, and an overall intensification of the most challenging aspects of our work as family law professionals. Adolescents are struggling not only within their families, but also socially and culturally as they strive to adjust to returning to school, extracurricular activities, and a society at large that is still reverberating from the impact of the pandemic and evolving social mores that offer more choices and less direction in terms of identities and behaviors. Teens, and the professionals who work with them, are carrying a load that is unprecedented in both its weight and complexity.

These authors paint a picture of a family court system in which the stakes are higher than they were previously. In effect, adolescent mental health issues serve the function of "heating" the family environment at the very time that the family is needing to quell the flames. However, we, as family law professionals, have the responsibility and the tools to help keep the systems cool. To do so effectively may require a reexamination of our standard ways of operating. That is, the traditionally adversarial system of family law may be creating a precarious environment for adolescents in crisis.

O'Brien and colleagues artfully challenge us to consider that adolescent mental health can become a "red herring" in high conflict cases, shifting focus away from parental conflict and poor coparenting and causing professionals to miss the important opportunity to recognize the deleterious impact that acrimonious coparenting has on children. This is a warning for professionals to stay focused on family systems approaches to high conflict cases, rather than allowing the child to become the "identified patient" in a dysfunctional system being driven primarily by parents in intractable conflict.

In some cases, however, adolescent mental health is not a red herring, but the central issue of concern that requires careful consideration by legal professionals and the courts. Children are being hospitalized for suicidality, entering residential treatment and wilderness programs in record numbers, and frequently returning home in a fragile state (e.g., Gutierrez-Sacristan et al., 2022). This often occurs within the context of pre-existing high conflict coparenting, parent–child contact problems, and other family systems dynamics that make reentry challenging for the family. Additionally, parents may differ in terms of their availability to monitor and provide parental care to the adolescent. In some cases, reconsideration of the custodial schedule and/or parenting plan is warranted, even if only on a temporary basis. Sometimes parents can agree to such a change, perhaps with the help of a parenting coordinator or coparenting specialist, but this situation can create a "perfect storm" that results in the family regressing to a high level of interparental conflict that makes decision-making and conflict resolution intractable. In such cases, court intervention may be warranted to protect the adolescent during this fragile period.

Greenberg and colleagues address such situations in which the child's health concerns are at the center of the family crucible in which children and adolescents have physical and/or emotional vulnerabilities. Even when a physical or mental illness is the primary concern for parents, the adolescent's condition can be significantly impacted by parental conflict directly (e.g., through the child witnessing the conflict or experiencing the lack of consistency in caregiving) and indirectly (e.g., through parental mismanagement of the condition due to parental disagreement and associated struggles related to interfacing ineffectively with the medical professionals involved). In this way, the relationship between adolescent mental illness and coparenting conflict is bidirectional, rather than linear, with each domain fueling the other. The authors highlight the fact that interventions focused on increasing coparenting collaboration are crucial to assisting teens and families in coping effectively and navigating treatment needs productively.

Sometimes situations involving teen mental health crises actually serve to bring parents together. Crisis can potentially shift parents into a deeper sense of commitment to a functional coparenting relationship, ending old patterns of bitter conflict and disconnection. Family members such as stepparents and grandparents may alter their prior unhappy stances and positions to create a healthier family environment for a child in crisis. While it would be naïve to assume such a response will emerge without significant support, a "jaded" view born of years of dealing with high conflict cases can lead us to miss the opportunity to bring a family together around the needs of an adolescent. In

such cases, the adolescent and his/her needs for stability can become a unifying theme for family members and professionals involved with the family.

The challenge of unifying parents requires effective communication among professionals working with the family system. Sullivan (2019) has highlighted the importance of the use of collaborative multidisciplinary teams when working with high conflict families. In light of the recent uptick in adolescent mental health concerns, there has arguably never been a more important time for a cross-disciplinary approach to working with divorcing families. Collaborating with other professionals working with the family serves several functions, including gathering additional information, understanding others' perspectives on the family (which may shift our own), and working collaboratively towards the shared goal of maintaining family stability. In this way, a collaborative team approach promotes a more stable environment for the children involved, which is crucial in situations involving teen mental health crises.

PROMOTING FAMILY CONNECTEDNESS

If we listen to the "voices from the field" and professional perspectives that we have gathered, there is an urgent call across disciplines to place the needs of adolescents in a more central role in our work. That is, we need to raise the bar on the "best interests" standard for adolescents in order to protect their mental health and ensure that family involvement in the legal system quells rather than exacerbates their struggles.

This goal is best accomplished by assisting families in maintaining cohesiveness and stability through the process of separation, divorce, and litigation. This is true not only for family law professionals trained as mental health providers, but for all professionals working with families in transition. Children and adolescents in litigating families are in a uniquely vulnerable position, and our collective response as professionals informs their experience of the family's separation and divorce. When all professionals are functioning to serve the family by promoting family cohesiveness and stability, we can move towards achieving the goal of protecting child and adolescent mental health.

Support for this position is evident in recent research on protective factors for adolescent physical and mental health. Researchers have found that family connectedness plays a key role in long-term well-being for teens. Steiner et al. (2019) gathered longitudinal data over a 14 year period from high school into young adulthood from over 15,000 participants, and found that family connectedness had "long lasting protective effects across multiple health outcomes related to mental health, violence, sexual behavior, and substance use" (p. 7). Adolescent protective factors "buffer the negative effects of risk factors," and family connectedness was defined as a key buffer, connoting "a sense of caring, support, and belonging to family" (p. 2). In Steiner's comprehensive study, family connectedness was found to have "protective effects for emotional distress, all violence indicators, including intimate partner violence, multiple sex partners, sexually transmitted infection (STI) diagnosis, and [two] substance use indicators" (p. 7). In effect, the researchers found that family connectedness, coupled with school connectedness, were impactful protective factors for adolescents across multiple health-related domains and over the course of their adolescence into young adulthood.

These findings have profound relevance to the field of family law, as "family connectedness" is, in effect, what we are primarily struggling to assist families in developing and maintaining. It is widely understood that maintaining a sense of family stability through separation and divorce is in the best interests of children and their parents. A caveat to this general adherence is in situations of family violence or other mental health and substance abuse issues in which distance is needed to protect family members who have suffered as a result of another family member's behavior. Even when connectedness seems preferable for parents and children, family stability and connectedness are at great risk during separation and divorce; while many families restabilize, others continue to struggle significantly in ways that reinforce or negatively impact the mental health of the children involved. This is especially true among high conflict families, as well as those struggling with parent–child contact problems. In both instances, the children are placed at the center of the conflict and controversy, and the family system becomes the battleground

upon which the dysfunctional coparenting dynamic plays out. In many such situations, the sense of family connectedness is essentially broken, and adolescents struggle to maintain a sense of connectedness to one parent, or the other, although some may find stability through distance from both parents, focusing instead on school connectedness (Steiner et al., 2019) or connectedness to other organizations or institutions. A family that has "come apart" is infertile ground for adolescents struggling with mental or chronic health conditions. With the current rates of mental illness and suicidality reported by teens, discussed in most of the pieces in this Special Section, we must ask ourselves how our current practices and procedures are meeting the needs of this population at-risk for negative long term sequelae.

This raises several questions for family law professionals. What does it mean to strive to maintain family connectedness in a family that is, by definition, trying to disconnect through divorce and separation? How can we help children maintain that sense of family connectedness in spite of their change of living circumstances, living arrangements, schedules, and even the emotional and economic stability of the parents upon whom they depend? What is our role as family law professionals in fostering that stability as we serve our various roles as attorneys, judges, custody evaluators, parenting coordinators, therapists, and mediators? Most importantly, would a focus on maintenance of family connectedness potentially serve a preventive or protective function and result in a reduction of child and adolescent mental health crises in high conflict family law cases?

Consider the impact of placing family connectedness at the center of our work. Rather than attempting to figure out who is the better parent, or how much time each parent should have with the older child/adolescent, we would focus on helping the family reformulate in a way that maintained the greatest sense of stability for the children and adolescents involved. In this way, we might avoid O'Brien's description of the "red herring" of mental health in adolescents, recognizing that it is truly a family systems problem, and thus any solution must be approached using this perspective. Otherwise, we are likely to miss the forest for the trees, focusing on the struggles of individual adolescents rather than recognizing that their mental health crises are part of a larger systemic problem related to how families divorce within the current systems we use.

THE WAY FORWARD

Achieving the goal of maintaining family stability through separation and divorce can be Sisyphean, especially in a system that can be adversarial and divisive. It begins with a willingness to focus on conflict resolution as a primary goal—a true "best interests" approach—for all professionals involved. This will require the engagement of legal and mental health professionals through the use of collaborative multidisciplinary teams, and listening carefully to those working with adolescents to understand each youth's unique vulnerabilities and needs.

Several of the authors in this special section have noted that such a paradigm shift requires a willingness to reconsider established ways of operating. **Freed** noted a need for increased sensitivity to adolescents' role in court proceedings, given the increase in mental health concerns. She notes that when, and how to involve them, and how to best intercede on their behalf, takes on new meaning when working with an adolescent in crisis. **Shear's** paper examines how the "old ways" aren't always fitting the new paradigms, resulting in a system that often fails adolescents in crisis. She points out that "family law has not normalized the need to adapt parenting plans for the teen years," and makes suggestions for how this might best be rectified. She also highlights the need for courts and related professionals to respond to teen mental health concerns in a timely fashion, in order to avoid crises. **McNamara** shares how the state of Colorado has responded to the increase in teen suicides by allowing teens to access mental health treatment without parental consent. Authors **Pasternak and Montgomery** and **O'Brien** offer examples of new types of programs for high conflict parents that are designed to fill current gaps in efficacious interventions. These are all important examples of the ways in which this mental health crisis leads us to envision new ways of conducting our work.

It is a unifying theme that such a paradigm shift will involve structural changes to a system that is currently designed to make one-time family-related decisions and "move on" to the next case. Courts need to order periodic follow-up status hearings for families with a child in crisis, to ensure that needed services are in place and effectively address the adolescent's emergent mental health needs. This may include moving towards an increased willingness to alter parenting plans fluidly to meet the needs of adolescents in crisis. While this may initially seem burdensome to courts, it will hopefully reduce future litigation and serve as a protective factor for the youth involved. It may offer opportunities to bring family court and mental health courts together, or to create such entities where they do not now exist.

Of course, some family systems risk becoming more destabilized from parenting plan changes, so such actions will require careful forethought and a working relationship between parents and professionals to discourage alignment and/or estrangement between the children and one parent over the other. Experienced forensic mental health professionals who assess and work with families in conflict may be best suited to advise courts in such matters, to assist in setting up supportive structures to help families manage through periods of transition. Care must be taken, however, that professionals do not mandate or encourage numerous professionals who would not all be needed if careful interdisciplinary collaboration was instituted among wealthier families, or mandate services that are not economically feasible for families with fewer economic resources.

The requirement for parents to collaborate effectively and shield the child from conflict must also be placed front and center, and parents unable to manage their conflict effectively should be required to participate in interventions to assist them with this goal. In addition to conflict resolution, parents also need to focus on developing the positive coping attitudes, skills, and strategies necessary to cultivate a sense of family connectedness for their children. To accomplish this, courts may need to play a more active role in assuring that teens in crisis are obtaining not only the mental health services they need, but also the family stability important to their ability to thrive.

This points to the broader issue of family law professionals and courts needing to recognize and respond to the developmental needs of teens. We tend to focus on younger children in hopes that by adolescence, kids will be "on their own" and able to thrive without much concern. This could not be further from the truth. Adolescence is a time of great paradox. At this stage of development, teens are striving for independence, yet requiring a great degree of parental oversight due to increased exploration and risk-taking behavior. Raising adolescents is a balancing act between maintaining consistent guidelines and boundaries (to keep them safe) while also allowing for age-appropriate exploration and freedoms (to allow them to grow). No longer existing in the paradigm of "Mom's time and Dad's time" as they once did, they are beginning to manage their own lives to a greater degree, and may need more freedom and flexibility to do so. Some teens will demand such freedoms, while others do not dare to rock the boat of family tensions. While such flexibility may create problems when there are parent–child contact problems (necessitating adherence to a more rigid schedule), teens in homes with more effective coparenting teams may have different time-sharing requirements than their younger siblings; this is developmentally normative and appropriate. While parents are the ultimate decision-makers, teens may need to have more "say" in such matters, thereby moving the family away from a "Mom versus Dad" dynamic, towards a more child-focused paradigm. Helping parents support this developmental stage, rather than polarizing in response to it, is the work we face as professionals.

Providing guidance in accord with child development and mental health needs requires family law professionals to receive education in our latest research and interventions. The field of child development is changing rapidly, incorporating findings from brain research and neurobiology, as well as cultural factors influencing gender identity, sexuality, racial and ethnic development, and social media impacts on all of the aforementioned. In family law cases with an adolescent in crisis, the involvement of mental health knowledge is of utmost importance and can help shift the family's and the court's focus to the needs of the child. When involving mental health professionals, it is crucial to define their roles such that they are not simply coopted into the divorce system, but instead, are allowed to participate in a neutral therapeutic and/or advisory role. In this way, they can assist legal professionals in shifting from a focus on family conflict to ways that functional parenting and coparenting can promote family stability, thereby assisting in stabilizing the adolescent's environment.

In summary, as a result of this special section, we argue for the following system level changes.

Through increased awareness of the adolescent mental health crisis, we can gain a newfound recognition that children and adolescents in divorcing and litigating families constitute a fragile population. This recognition may lead us to approach them with a greater degree of sensitivity, and even humility, in our work. By striving to better understand their needs, and allowing those needs to drive our work rather than focusing primarily on the parents and the complexity of their conflict, we might best promote the sense of family connectedness needed to protect children at this most important and pivotal developmental stage.

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Association of Family and Conciliation Courts

Guidelines for Court-Involved Therapy

Association of Family and Conciliation Courts

Guidelines for Court-Involved Therapy

Approved by the AFCC Board of Directors
October 2010

Table of Contents

PREAMBLE

The Guidelines for Court-Involved Therapy have been formulated to assist members of the Association of Family and Conciliation Courts (AFCC) and others who provide treatment to court-involved children and families. The Guidelines are also intended to assist those who rely on mental health services or on the opinions of mental health professionals in promoting effective treatment and assessing the quality of treatment services. The Guidelines are also intended to assist the Courts to develop clear and effective Court orders and parenting plans that may be necessary for treatment to be effective.

AFCC does not intend these Guidelines to define mandatory practice. They are a best-practice guide for therapists, attorneys, other professionals and judicial officers when there is a need for therapeutic interventions with court-involved children or parents. While available resources and local jurisdictional expectations may influence the types of therapeutic services provided by a Court-Involved Therapist (CIT), the purpose of these guidelines is to educate, highlight common concerns, and to apply relevant ethical and professional guidelines, standards, and research in handling court-involved families.

INTRODUCTION

For the purposes of these guidelines, court-involved therapists are mental health professionals who provide therapeutic services to family members involved in child custody or juvenile dependency Court processes. Family and juvenile Court cases involving therapeutic services introduce unique factors and dynamics that require consideration in the treatment process. Both the treatment process and information provided to the therapist are likely to be influenced by the family's involvement in a legal process. While appropriate treatment can offer considerable benefit to children and families, inappropriate treatment may escalate family conflict and cause significant damage.

The Guidelines for Court-Involved Therapy are the product of the Court-Involved Therapist Task Force, appointed by AFCC President Robin Deutsch in 2009. Task force members were: Hon. Linda S. Fidnick, Co-Chair; Matthew Sullivan, Ph.D., Co-Chair; Lyn R. Greenberg, Ph.D., Reporter; Paul Berman, Ph.D.; Christopher Barrows, J.D.; Hon. R. John Harper; Hon. Anita Josey-Herring; Mindy Mitnick, M.Ed., M.A.; and Hon. Gail Perlman.

DEFINITIONS

A. Definitions Regarding Professional Roles

Community Therapist: Any mental health professional providing psychotherapeutic treatment of a parent, child, couple or family who is not involved with the legal system at any time during the treatment.

Court-Involved Therapist (CIT): Any mental health professional providing psychotherapeutic treatment of a parent, child, couple or family who is, at any time during the treatment, involved with the legal system.

Court-Appointed Therapist: Any mental health professional providing psychotherapeutic treatment of a parent, child, couple or family undertaken because the particular psychotherapist was ordered by a judge to provide treatment. The Court order designates the specific psychotherapist and may describe the expected treatment.

Court-Ordered Therapist: Any mental health professional providing psychotherapeutic treatment of a parent, child, couple or family undertaken because it was ordered by a judge. The Court order does not designate a specific therapist and may describe the expected treatment.

B. Definitions Regarding Experts

Expert: The word expert generally refers to a person with specialized knowledge of a particular subject matter.

In the legal context, the word "expert" refers to a witness who has been specifically qualified by the Court in a particular case to provide opinion evidence within a circumscribed subject matter determined by the Court. To qualify an expert, the Court first reviews evidence of the witness's expertise of that subject matter, unless the admissibility of the professional's opinion as an expert has been previously stipulated to by the parties or established by the Court.

(a) Treating Expert: A mental health professional, who currently serves or has served as the therapist for a parent, child, couple or family involved with the legal system. If the therapist is qualified by the Court as an expert, testimony should be limited to the therapist's particular area of expertise and issues directly relevant to the treatment role. To the degree permitted by the Court in a specific case, the treating expert can provide expert opinion regarding a parent or child's psychological functioning over time, progress, relationship dynamics, coping skills, development, co-parenting progress, or need for further treatment, as appropriate to the therapist's role. In contrast to the forensic expert, the treating expert does not have the information base or objectivity necessary to make psycho-legal recommendations, such as specifying parenting plans, legal custody, or decision-making authority.

(b) Mental Health Forensic Expert: A mental health professional hired by a party or appointed by a Court to answer a legal question through the application of psychological methods. A mental health forensic expert, for example, may perform a custody evaluation, a psychological evaluation to answer a particular question formulated by the Court, a competency evaluation, an evaluation to assist the Court in the decision-making process regarding custody and/or access. Their testimony might include psycho-legal issues such as recommendations about parenting plans, legal custody or decision-making authority.

C. General Definitions

Client/Patient: A parent, child, couple or family receiving psychotherapeutic treatment from any of the mental health professionals defined in this section

Collateral: A person, not a client or patient, who has information bearing on the client or patient and whom a mental health professional, in any role defined in this section, interviews to obtain information or engages directly in the client or patient's treatment.

Confidentiality: An ethical duty, also established by statute, rules or case law in some jurisdictions, owed by a mental health professional to a client/patient, subject to some exceptions, to maintain the client/patient's privacy by not revealing information received from the client/patient.

Privilege: A legal right, conferred by statute in many jurisdictions and limited by exceptions, held by a mental health professional's client/patient to prevent the mental health professional from disclosing confidential information in a legal proceeding. Some jurisdictions have a formal process for determining whether or not and under what circumstances the privilege will be waived by or on behalf of the client/patient to allow testimony by the mental health professional in a court-related matter. (Issues regarding privilege and confidentiality are described in Guideline 7.)

Conflict of Interest: A situation in which personal, professional, legal or other interests or relationships have the potential to compromise or bias the mental health professional's judgment, effectiveness or objectivity. A conflict of interest may also occur in some jurisdictions based on the establishment of an appearance of conflict standard rather than an actual conflict.

Informed Consent:

(a) A client/patient's decision to consent to a proposed treatment or a proposed release of confidential information by a mental health professional, after the client/patient has received reasonably full and accurate information from the mental health professional as to the risks, benefits and likely consequences of the decision to consent.

(b) The term is used colloquially by mental health professionals to mean the *process* by which a client/patient receives the information needed to make an informed decision. The process usually includes discussion and a written agreement between the mental health professional and the client/patient as to the information provided and the client's understanding of it. (See Guideline 6.)

GUIDELINE 1: ASSESSING LEVELS OF COURT INVOLVEMENT

1.1 A CIT should assess the degree to which legal processes will impact the treatment and consider issues that may impact the client or parent's functioning in treatment, and the implications of treatment interventions on the legal processes

(a) The CIT should be aware that cases may have different degrees of Court involvement, and may also change in their degree of Court involvement over time.

(b) The CIT should obtain information about how the decision to enter therapy was made, who was involved in the decision, and what outcomes are expected from the treatment or the therapist by parents, other professionals, or the Court.

(c) The CIT should consider the variety of mechanisms through which court-involved families can enter treatment, and the implications of each of those circumstances:

(1) A parent involved in a Court case recognizes his/her own or child's distress and seeks treatment.
(2) A parent seeks therapy for him/herself or a child, in hopes of improving his/her own position in the Court case and securing the therapist's direct or indirect participation (report to a custody evaluator, etc.).
(3) Parents are ordered to obtain therapy for themselves or a child, but select from community practitioners with no specific agenda, reporting expectation or requirement.
(4) The Court orders therapy to address particular issues, such as child distress, high-conflict dynamics, reunification, etc. The order may include some degree of reporting requirement, or contingencies allowing reporting.

(d) The CIT should consider the potential impact of Court involvement on adults' functioning in treatment. The stress of Court involvement and the importance of the outcome to those involved can generate conscious or unconscious distortion of information and changes in the clients' or parents' expectations of the therapist.

(e) The CIT should consider the impact of his/her natural working alliance with the client. This may lead the therapist to align with the client's position in the legal dispute, thus impairing the CIT's ability to prepare the client to cope with likely outcomes and stresses in the legal process. While a client may equate his or her best interests with prevailing in the legal dispute, CITs must remain cognizant that their role is to promote successful psychological

functioning in the client, not to serve as an advocate or a forensic expert or produce a particular outcome in the legal process.

1.2. Special considerations for court-involved roles with children

(a) Children's behavior and statements may vary markedly based on the circumstances of treatment.

(b) The CIT has an enhanced obligation to consider multiple treatment hypotheses and be knowledgeable about children's developmental tasks and needs.

(c) The CIT should use particular caution to ensure that he/she has adequate data on which to base any opinions or assessments, and to form and express such opinions only within confines of the therapeutic role and available information, while remaining cognizant of the impact of Court involvement on the family and on treatment information.

(d) The CIT must, whenever possible, obtain each parent's perspective in the treatment process and maintain professional objectivity when interpreting statements and behaviors of children. The CIT should use particular caution in interpreting statements, play or drawings that appear to express positions on adult issues to avoid inaccurate or incomplete assessment of a child's developmental needs, expressed thoughts and feelings.

(e) The CIT should be aware of the potential impact of parental needs and expectations on treatment involving children or adolescents. The CIT should be particularly aware that:

  (1) A parent may have a genuine desire to obtain treatment or provide it to a child, but may also have expectations that the therapy will support the parent's own goals in the legal conflict.
  (2) A child or adolescent who is expressing a "position" regarding a contested issue in the legal conflict may have external influences on their perceptions, or that negatively impact their coping skills.

(f) While it is common in traditional treatment for one parent to be more involved in child treatment than the other, this therapy structure creates a risk in court-involved treatment. A CIT should consider *both* parent-child relationships and each parent's perspective in court-involved treatment.

GUIDELINE 2: PROFESSIONAL RESPONSIBILITIES

2.1 A CIT should establish and maintain appropriate role boundaries

(a) A CIT should inform potential clients, and others who may be relying on the therapist's opinion or services, of the nature of the services that can be offered by the therapist and the limits thereof. This includes providing thorough informed consent to clients/parents and appropriate information to others who may rely on the therapist's information. (See Guideline 6 and Guideline 10.)

(b) A CIT should resist pressure from anyone to provide services beyond or antithetical to the therapeutic role, as defined by recognized professional and ethical standards or guidelines.

(c) A CIT should explain to clients any decisions to decline to provide certain services. If others (e.g., the Court guardian *ad litem*, minor's counsel or agency) have requested services that the CIT considers inappropriate, the CIT should also explain decisions to decline these requests, to the degree that information provided is not privileged or privilege has been waived.

(d) A CIT should be prepared to modify elements of the therapeutic process, if appropriate, and to explain the necessity for the modification.

(e) A CIT should apprise the Court of any conflicts between the Court's expectations and the ethical and professional obligations, or role limitations, of the therapist.

2.2 A CIT should demonstrate respect for parties, families, the legal process and its participants

(a) A CIT should communicate respect for the legal system to clients, collaterals, and others who may rely on the therapist's work, information or opinions.

(b) A CIT should provide a thorough informed consent processes to parents, and age-appropriate explanations to children, as described in Guideline 6.

(c) A CIT should communicate, within the limits of any applicable privilege, regarding the limits and responsibilities of the therapist's role.

(d) A CIT should respect each parent's rights, as defined by relevant orders or law, regarding knowledge of, consenting to, and/or participating in a child's treatment.

(e) A CIT should be knowledgeable about appropriate expectations for developmentally acceptable behavior in children while respecting their independent feelings, perceptions, and developmental needs.

(f) A CIT should communicate with counsel in a balanced manner when in a neutral role and authorized to do so.

2.3 A CIT should provide clear, non-technical communication of observations and opinions to adult clients, parents of child clients, and other professionals when appropriate and permitted by applicable privilege

2.4 A CIT should maintain professional objectivity

(a) A CIT should actively seek information that will provide the most thorough understanding of his/her client's circumstances and issues, while remaining within the limits of the therapist's assigned therapeutic role in the case.

(b) When children are involved in treatment, a CIT has an enhanced obligation to consider multiple hypotheses, seek information and involvement from both parents and avoid the biasing effects of one-sided or limited information.

(c) A CIT should make efforts to consider and assess treatment issues from the perspective of each involved individual. This does not preclude maintaining a strong therapeutic alliance with a parent client/patient in individual therapy, but may require exploring with the client how others may perceive the issues.

(d) To the degree possible in the given therapeutic role, the CIT should remain aware of the information emerging in the legal process in order to assist the client in coping with it.

2.5 The CIT should manage relationships responsibly

(a) A CIT should recognize that the therapeutic relationship may change as a family's involvement with the Court changes or as the therapist communicates to other professionals, collaterals or the Court.

(b) If a parent or family who has not previously been court-involved becomes involved in a legal process and asks the therapist to continue services, the CIT should discuss with the relevant individuals and/or family members the potential effect of Court involvement on the therapy. This should include discussion of potential requests for release of therapeutic information to others including a child custody evaluator, parenting coordinator, other professionals, or the Court.

(c) If a CIT who has not previously been involved with a client's ongoing litigation is asked to provide information or have other involvement in the legal process, the CIT should notify the client and/or the client's legal representative of such requests. If the CIT believes the release of information

will adversely impact the client, the CIT should seek legal advice and notify the Court.

(d) The CIT should clearly document informed consent on the above issues.

2.6 A CIT should maintain accountability

(a) The therapist in a child-centered role should recognize that active intervention may result in the dissatisfaction of one or both parents, but should nevertheless maintain focus on the welfare of the child client.

(b) If disputes arise regarding interpretation of Court orders governing treatment, the CIT should seek direction or clarification from the Court, or an authorized Court representative in the case.

(c) The CIT should recognize that others in the legal system (e.g., custody evaluator, parenting coordinator, child's counsel or the Court) may have a role in monitoring or reviewing the therapeutic process.

(d) The CIT should recognize that his/her judgments, interventions, reports, testimony and opinions may have a profound impact on outcomes for children and families. The CIT should remain objective at all times, should use caution in forming and expressing opinions, and should use particular caution in drawing conclusions from limited observations or sources of information.

(e) A CIT should recognize that the dynamics of a court-involved case may create conflicts or disagreements with litigating parents or lead to demands that the therapist withdraw from the case. The CIT should recognize that therapeutic confrontation of a parent or a child, or a refusal to accede to the wishes of a parent or child, may frustrate that individual's desires, but does not necessarily constitute a conflict of interest. Such therapeutic confrontation may be therapeutically appropriate or even essential. In such a situation, withdrawing from the case or abandoning the intervention, unless terminated by the client, may be antithetical to the interest of the child or family.

GUIDELINE 3: COMPETENCE

3.1 A CIT has a responsibility to develop and maintain specialized competence sufficient for the roles they undertake

3.2 Gaining and maintaining competence

(a) A CIT has a responsibility to obtain education and training, and to maintain current knowledge, in areas including, but not limited to:

(1) Characteristics of divorcing/separated families and children

(2) Family systems and other systems in which court-involved families interact
(3) The impact of high interparental conflict on post-separation custody arrangements
(4) Effective interventions with divorcing or separated families
(5) Adaptations of traditional therapeutic approaches that may be Necessary to work with divorcing or separated families
(6) characteristics and needs of special populations who may be Involved in treatment
(7) Ethical issues and applicable local legal standards

(b) A CIT should utilize continuing education and professional development resources to maintain current knowledge of issues relevant to court-involved treatment.

(c) A CIT may also gain some of the required knowledge through experience and consultation with colleagues; however, clinical experience should not be a substitute for knowledge of the underlying science, relevant research, legal issues and standards of practice.

3.3 Areas of competence

(a) The CIT should maintain knowledge and familiarity with current research related to psychological issues in areas including, but not limited to:

(1) Child development and coping, including developmental tasks
(2) Child interviewing and suggestibility
(3) Children's decision-making ability, including appropriate means of understanding children's abilities and interpreting expressed preferences or opinions
(4) Factors in divorcing families that increase risk to children, or promote resilience in children
(5) Domestic violence
(6) Child abuse and child welfare
(7) High conflict dynamics, including risks to children from exposure to parental conflict, parental undermining, alienation and estrangement
(8) Treatment approaches, including both traditional methods and adaptations for divorcing or separated families
(9) Parenting and behavioral interventions
(10) Special needs issues, including medical issues, psychiatric diagnoses, substance abuse, learning or educational problems, developmental delays, etc.
(11) Ethnic, cultural, and sexual orientation differences among families

(b) The CIT should maintain knowledge and familiarity with legal information and issues related to court-involved therapy, including, but not limited to:

(1) Statutes and local Court rules in the therapist's jurisdiction
(2) Case precedents relevant to court-involved treatment
(3) Interactions and potential conflicts between governing mental health practice and family Court expectations or family law statues
(4) Ethical and professional guidelines and standards applicable to the role of the CIT, obtaining ethics consultation as appropriate
(5) Circumstances under which it may be necessary or appropriate for the therapist to consult an attorney

(c) The CIT should seek appropriate consultations when issues arise that are outside of the CIT's expertise.

3.4 Understanding of professional roles and resources

(a) The CIT should be familiar with the roles of other professionals with whom the CIT may interface while providing therapy in a case.

(b) The CIT should understand the roles of the child custody evaluator and the parenting coordinator, and the impact that the appointment of such professionals may have on both the process of therapy and the privacy of therapeutic information.

(c) The CIT should understand the roles of the minor's counsel or guardian *ad litem*, and should be aware of the laws governing confidentiality of treatment information when one of these professionals is appointed.

3.5 Representation of competence, state of professional knowledge

(a) The CIT should accurately represent his/her areas of competence, advise clients/parents if an issue arises that is beyond the CIT's knowledge and expertise, and initiate consultation and/or referral, when appropriate.

(b) The CIT should understand the limits of scientific knowledge and use caution to avoid overstating the certainty or parameters of professional opinions. (See Guideline 10.)

3.6 Consideration of impact of personal beliefs and experiences

(a) The CIT should remain familiar with current research on the impact of personal bias, personal beliefs and cultural and value differences, factors that may contribute to bias, and efforts that may be undertaken to contain or manage potentially biasing conditions in the CIT's work.

(b) The CIT should recognize and acknowledge that powerful issues may arise in court-related cases that generate personal reactions in the therapist or others, and take steps to counterbalance exposure to information or otherwise manage these issues.

(c) The CIT should obtain appropriate consultation to assist in maintaining professional objectivity.

GUIDELINE 4: MULTIPLE RELATIONSHIPS

4.1 The CIT should avoid serving simultaneously in multiple roles, particularly if these create a conflict of interest. For example, the CIT should not serve simultaneously as therapist and evaluator or as therapist and friend. Similarly, the CIT is strongly discouraged from performing different roles sequentially, as, for example, a therapist who becomes an evaluator or a therapist who becomes a parenting coordinator.

4.2 The CIT should disclose to all relevant parties any multiple relationships that cannot be avoided and the potential negative impact of such multiple roles.

(a) The CIT who discovers that he/she is performing multiple roles in a case should promptly seek to resolve any conflicts in a manner that is least harmful to the client and family. The CIT should clarify the expectations of each role and seek to avoid or minimize the negative impact of assuming multiple roles.

(b) The CIT should recognize that relationships with clients are not time limited and that prior relationships, or the anticipation of future relationships, may have an adverse effect on the CIT's ability to be objective.

(c) The CIT should attempt to avoid conflicts of interest and should address them as soon as they arise, or the potential for conflict becomes known, by:

(1) Identifying a real or apparent conflict of interest as soon as it becomes known to the CIT
(2) Refusing to assume a therapeutic role if personal, professional, legal, financial or other interests or relationships could reasonably be expected to impair objectivity, competence or effectiveness in the provision of services
(3) Communicating with the client or potential client or counsel, and, if necessary, with the Court, about the existence of the conflict.
(4) Recognizing that the appearance of a conflict of interest, as well as an actual conflict of interest, can diminish public trust and confidence both in the therapeutic service and in the Court
(5) Differentiating between conflicts that require declining to assume or

withdrawing from the therapeutic role, as opposed to multiple or sequential roles that may be undertaken with waivers from the client or parent

(6) Recognizing the risks of undertaking conflicting roles, even if the client or parent signs a waiver

(7) Clearly documenting the disclosure of any waived conflict, the client's ability to understand it, and the client's waiver. The client must receive a clear explanation of the conflict, and it may also be necessary to provide such explanations to other professionals or agencies relying on the therapist's work or information

GUIDELINE 5: FEE ARRANGEMENTS

5.1 The CIT should establish a clear written fee agreement with the responsible parties prior to commencing the treatment relationship

(a) A CIT may send a written fee agreement to the parties and/or client(s) prior to commencing treatment.

(b) If the case is not court-involved, a CIT may discuss the terms and fee requirements of treatment directly with the parties and/or client. This discussion should be documented in the CIT's record.

(c) If the case is already court-involved, or likely to be, a CIT may send the fee and consent agreements to counsel.

5.2 The CIT should provide written documentation to each responsible party

(a) Documentation should include a description of the treatment services to be provided, including all of the elements of informed consent described in Guideline 6.

(b) A CIT should provide a fee agreement that contains, at a minimum:

(1) A description of all services and charges

(2) Expectations regarding payment, including, if applicable:
   (i) fees associated with missed or cancelled sessions,
   (ii) costs/fees generated by one parent,
   (iii) consequences of non-payment, including its potential impact on continued provision of services,
   (iv) the use of collection agencies or other legal measures that may be taken to collect the fee (see attached sample agreement).

(3) Policies with regard to insurance reimbursement, if any. This should include issues such as identifying the person responsible for submitting the insurance form, payment for covered and non-covered

services, responsibility for submitting treatment plans (if required by the insurer) and the consequences of using insurance.

(4) Policies regarding advance payments, if any, for treatment services and the use of those payments

(5) A procedure for handling of disputes regarding payment

(c) If the therapy is court-ordered, the CIT should provide to the Court all information required to engage the CIT so that the Court can issue an appropriate and comprehensive order. The written fee agreement may be incorporated into the Court order that initiates the therapy. The therapist should request that the Court specify the party responsible for the payment or the specific apportionment between the parents or parties. In the event that the Court order fails to address the issue of fees adequately, the therapist should take appropriate steps to obtain clarification from the Court before providing services. Arrangements should be sufficiently clear to prevent or resolve most fee-related disputes, and for a future judicial officer or reviewer to be able to resolve any such disputes submitted to the Court.

(d) If treatment is terminated or suspended due to non-payment, the CIT should conduct the termination or suspension in accordance with the order, fee agreement and ethical principles.

(e) The CIT should maintain complete and accurate written records of all amounts billed and all amounts paid.

GUIDELINE 6: INFORMED CONSENT

6.1 At the outset of therapy, the CIT should provide a thorough informed consent process to adult clients and parents or legal guardians if the therapy involves the child

(a) A CIT has a professional obligation to inform the client of the limits of confidentiality and privilege at the outset of the therapeutic relationship, to promote informed decision-making throughout treatment and to document such explanations in the CIT's record. The CIT should clarify that these cautions do not constitute legal advice, and that the CIT will obey the Court's orders regarding treatment information.

(b) The informed consent should use language that is understandable and includes, at a minimum, information about the nature and anticipated course of the therapy, risks and benefits of the therapy, fees, the potential involvement of other individuals in the therapy, and a discussion of confidentiality.

(c) The CIT should be aware of state laws that impact confidentiality and access to records and these should be incorporated in the informed consent.

(d) Clients or their counsel should have an opportunity to ask questions, obtain answers, and discuss their concerns. These discussions should be documented in the CIT's record.

6.2 If a child is to be involved in treatment, there are special considerations

(a) A CIT should generally avoid accepting a child into treatment without notifying or consulting with both parents.

(b) A CIT should request copies of Court orders or custody judgments documenting each parent's right/authority to make decisions regarding treatment and delineation of each parent's access to treatment information.

(c) In rare and urgent cases, such as when there is strong reason to suspect a risk to a child's safety, a CIT may accept a child in treatment at the request of one parent. This should only occur if that parent has clear legal authority to consent and pending efforts to either notify the other parent or obtain permission from the Court; however, the CIT should be aware that such a decision may increase risk to the child, and to the CIT.

(d) A CIT should explain the nature and purpose of the treatment to a child in age-appropriate language. It may be necessary to revisit these issues as treatment proceeds.

(e) A CIT should discuss the limits of parental involvement and confidentiality with the parents or guardians of a child or adolescent involved in treatment.

6.3 When a CIT becomes involved in treatment at the request of a third party such as the Court, an attorney, or a social service agency, the CIT should be especially attentive to informed consent issues

(a) The CIT should identify to the client the name of the person or agency that requested the services and the potential impact this may have on the treatment.

(b) If an adult client or parent does not sign the informed consent, or otherwise has significant disagreements with the treatment process, the CIT should defer commencement of services and refer the client back to the third party agency or the Court for clarification.

(c) If the CIT has been appointed by the Court to provide treatment to one or more adults and an adult refuses to sign consent documents, the CIT should defer commencement of services until consent is obtained or the Court takes action to resolve the issue.

(d) If a CIT is asked by anyone to provide treatment to a child and one parent supports treatment while the other refuses consent, the therapist should refer the parties back to the Court for resolution of the dispute between the parents, and then proceed as the Court directs.

(e) If the court-ordered treatment is to proceed, it is recommended that the CIT require a treatment order, specifying the nature of the services to be provided and the parameters of treatment, before proceeding with treatment.

6.4 When more than one individual participates in the therapy, the CIT should clarify with each person the nature of the relationship between the participants and between each participant and the therapist. The CIT should also clarify his/her roles and responsibilities, the anticipated use of information provided by each person, and the extent and limits of confidentiality and privilege

6.5 On a case-specific basis, the CIT should explain to the client the manner in which treatment information will be handled. Issues to be clarified may include, but are not limited to:

(a) Whether the consent of one or both parents will be required to release information from conjoint, co-parenting or marital therapy

(b) Whether information will be released to a custody evaluator, parenting coordinator, the Court, or any other individual, and the extent of the information to be released

(c) Whether, and how, the CIT will communicate to the Court in the event that one or both parents do not cooperate with court-ordered treatment

(d) What will happen if the CIT is subpoenaed to give testimony in a court-related matter

(e) What information can be released to insurance companies, the Court, the other parent, or other entities to enable the CIT to collect his/her fees.

6.6 The parent/client should be encouraged to consult with counsel before signing a therapy/informed consent agreement, if the parent or client is represented

6.7 If the CIT's level of Court involvement changes or requests are made to change the CIT's role, the CIT should inform the client of the risks, benefits and impact of any potential changes in treatment

(a) The CIT should obtain consultation before contemplating a change in his/her role that might create a conflict of interest or alter therapeutic alliances.

(b) If the CIT becomes aware of potentially conflicting roles, he/she should take reasonable steps to immediately disclose, clarify and discuss the potential conflicts and any potential adverse impact. The CIT should make best efforts to minimize any negative impact, including withdrawing from the case, if appropriate.

(c) If the parties consent to a change in the CIT's role, the CIT should document the revised informed consent process.

6.8 The CIT should be sensitive to the possibility of being asked to provide feedback to third parties or to testify as a witness. The CIT should inform the client of this potential at the beginning of the informed consent process and as necessary thereafter.

(a) The CIT should take reasonable steps to clarify the limits of the therapeutic role, the potential scope of information to be released, and the potential implications of the release of information or the testimony for the client (see Guideline 7). In no case should the CIT attempt to provide legal advice to the client.

GUIDELINE 7: PRIVACY, CONFIDENTIALITY AND PRIVILEGE

7.1 The CIT should understand the principal issues that arise in court-related therapy in regard to client/patient confidentiality and privilege.

(a) The CIT should be aware that laws and standards vary markedly among jurisdictions, and there may be conflicts in the law within a single jurisdiction. Issues that may vary among (and within) jurisdictions include, but are not limited to:

(1) The identified client
(2) Assertion and waiver of the client's privilege
(3) Under what circumstances the mental health professional can or must disclose confidential information

(b) The CIT should be aware that ethical, clinical, and legal issues related to confidentiality/privilege may differ depending on whether a parent, child, couple or family is in treatment.

(c) The CIT should be aware of clinical issues related to disclosure of confidential information. (See Guideline 8.7.)

7.2 The impact of litigation on decisions regarding use of treatment information.

(a) The CIT should also be aware that a client or parent's legal case may be affected by the client's decision to release or decline to release treatment information. The CIT should encourage the client/parent to seek appropriate legal consultation before making this decision.

(b) The CIT should consider the impact of the Court context on a client's decisions about the use of treatment information and should take precautions accordingly.

(c) The CIT should consider that situational pressures may affect the client or parent's judgment or authority on the issue of waiving the privilege regarding treatment information. These pressures may include requests from the Court or other professionals with influence on the legal proceedings (e.g., a custody evaluator or parenting coordinator) that the parent waive his/her own, or the child's privilege as to the treatment relationship.

(d) The CIT should be aware that in some jurisdictions or situations, parents may not hold the right to waive or assert the child's privilege in court-involved treatment or treatment of the child. In some jurisdictions, a CIT has the option or duty to resist disclosure of information, or seek direction from the Court, if the CIT determines that disclosure of the information risks the welfare of the child. The CIT should be familiar with the appropriate procedures for his/her jurisdiction.

7.3 A CIT should recognize the limits of his/her expertise and, when in doubt as to whether information requested about treatment can be released, seek legal advice or request direction from the Court

7.4 Ongoing obligation to inform clients

(a) A CIT should revisit the discussion of confidentiality with the client as circumstances change, or as issues arise in therapy that may result in the disclosure of treatment information.

(b) If therapy is court-ordered and there is dispute regarding privacy, confidentiality and privilege, the CIT should seek clarification from the Court prior to commencing services. If a dispute arises as to the interpretation of the Court order after services have begun, the CIT should seek direction from the Court before releasing information.

7.5 Special issues in children's treatment

(a) A CIT should be familiar with general provisions governing confidentiality of children's treatment information in his/her jurisdiction, including:

(1) Who holds the child's privilege and how a child's privilege can be waived or asserted
(2) Under what circumstances a child or adolescent may have a role in this decision
(3) How the CIT should respond if he/she receives conflicting instructions from the parents
(4) How the CIT should respond if he/she believes that disclosure of treatment information poses a substantial risk of harm to the child

(b) At the outset of a child's treatment, the CIT should clarify the provisions of the order or therapy agreement regarding the child's treatment information. These issues include, but are not limited to:

(1) How information about a child's progress will be shared with parents
(2) Whether the consent of one or both parents will be required to release information about the child's progress
(3) The role that the child's thoughts and feelings will play in determining what information is shared, and how it is shared
(4) Circumstances in which the CIT may be required to release information to the parent or other professionals
(5) Circumstances that might require further discussion, clarification or modification of the order or agreement as the treatment progresses

(c) A CIT should prepare the child client for the release of treatment information, address the child's feelings about the issue, and assist the child in coping with any stressors that may result.

(d) The CIT should adapt explanations to the developmental and situational needs of each child.

(1) When working with a child client, the CIT should clarify the limits of confidentiality in developmentally appropriate language
(2) A CIT should not make blanket promises to a child that treatment information will be confidential

7.6 Considerations for therapists covered under the Health Insurance Portability and Accountability Act (HIPAA)

If the CIT is a HIPAA-covered entity, he/she must be aware of his/her obligations under the Act, and the how those obligations may change if the client or family

becomes involved with the Court. When requirements under HIPAA appear to be in conflict with other laws or Court orders, the CIT should obtain legal consultation.

7.7 Responding to requests for treatment information from third parties

(a) The CIT should request a copy of the release signed by the client, former client, parent, or other authorized person. The CIT should not communicate with a third party without an appropriate release or order of the Court authorizing disclosure.

(b) Prior to providing client information to a third party, the CIT should attempt to inform the client or former client about the request for release of information.

(c) The CIT should inform the client or former client of the nature of the information that may be released to a third party if the client waives the privilege. If appropriate, the CIT should also refer the client or former client to his/her attorney to assist the client in making this decision.

(d) A release does not supersede a Court order; therefore, prior to releasing information to a third party, a CIT should consult any agreement or Court order that governs the treatment.

7.8 Responding to a subpoena

(a) A CIT should be aware of differences between subpoenas and Court orders.

(b) A CIT who has received a subpoena should consider consulting an attorney familiar with both legal issues in the jurisdiction related to mental health law and the requirements of the Court in which the family is involved. Procedures, requirements, and the CIT's options will vary depending on the jurisdiction, whether the case is being heard in a family Court or juvenile dependency Court, and many other issues.

(c) A CIT should not automatically respond to a subpoena by disclosing written or oral information.

(d) A CIT should not ignore a subpoena.

(e) The CIT may wish to consider the additional guidance provided in Appendix A regarding specific steps that may be helpful in responding to a subpoena.

7.9 Responding to a Court order for release of treatment information

(a) If the CIT is ordered by the Court to release information, particularly over the

objection of one of the parties, the CIT should request a written order specifying the parameters of information to be released.

(b) If there are outstanding legal questions regarding what information can be released (such as whether the CIT can release information from other agencies or child protective services), the CIT may wish to obtain the assistance of an attorney who can bring these issues to attention of the Court and obtain clarification or direction.

7.10 Appealing a Court order

There are some circumstances in which a CIT may believe that disclosing information may violate ethical or professional practice guidelines applicable to mental health practice. In such a case, the CIT may wish to consult an attorney familiar with the laws of mental health privilege/confidentiality in that jurisdiction.

GUIDELINE 8: METHODS AND PROCEDURES

8.1 The CIT should adhere to the methods and procedures generally accepted in his/her particular discipline. In addition, the CIT should maintain methods and procedures consistent with being involved in situations, which may include litigation, testimony, and the reporting of various matters to Court, parties, or their attorneys.

8.2 Obtaining necessary information if the therapy is court-ordered

(a) The CIT should attempt to obtain all information necessary to conduct the court-ordered therapy and should discuss the goals of the court-ordered therapy with the client.

(b) As appropriate to the specific case, the CIT should request information that may be necessary for effective treatment. This may include permission to speak to a prior therapist or other involved professionals, copies of prior Court orders, therapy records, and reports from child custody evaluators, child protective services, or a guardian *ad litem.*

(c) The CIT should obtain necessary information, including copies of relevant Court orders, to confirm that his/her role is clearly defined and consistent with the therapeutic role and the CIT's expertise.

(d) If the CIT is unable to obtain information from the parties or counsel that is necessary to conduct treatment, the CIT may apply to the Court for further direction if the CIT has obtained appropriate releases. Application to the Court should be preceded by proper notice to the parties and counsel.

8.3 Therapeutic role and process

(a) The CIT has a responsibility to identify both the intended clients and any others intended to be the beneficiaries of the intervention.

(b) When the intended beneficiary of the intervention is an individual client, the primary focus of the therapist is the client's welfare and treatment is implemented for the benefit of the client. Therapists with different treatment orientations may identify different treatment goals, but all focus on improving client's functioning.

(c) In other cases, a relationship or family unit may be the identified client or may be the participants in counseling, but the goal may be to reduce conflict or promote behavior change for the benefit of the child (e.g., co-parenting or conjoint/reunification therapy).

(d) The CIT should clearly identify the goals, procedures and beneficiaries based on any relevant orders and in collaboration with the client(s) and other professionals as appropriate, and should clearly communicate this information to participants in the therapy.

8.4 The CIT should understand that the information provided by the client during the course of the treatment is based upon the client's experience and perspective, which may sometimes be distorted or lacking balance and comprehensiveness

(a) The CIT should strive to maintain professional objectivity, and to remain aware of the impact of the therapeutic alliance on the therapist's information and perspective.

(b) The CIT should actively consider alternative hypotheses regarding the information (i.e., data) he/she is receiving in the treatment.

(c) The CIT should strive to be aware of societal and personal biases and continuously monitor his/her actions for evidence of potential bias. Awareness of research and focus on the treatment data inform the CIT and help limit the potential for bias. The CIT should consider withdrawing from a case when he/she is unable to manage a known bias and/or is unable to maintain objectivity.

(d) The CIT should be aware that the treatment may be influenced by the client or family's involvement in legal processes, and that the legal process may be influenced by the actions of the therapist.

(e) The CIT must constantly guard against/protect his or her work from threats to professional objectivity and role boundaries.

8.5 Selecting appropriate treatment methods

(a) A CIT should not exceed the bounds of his/her professional competence in his/her diagnosis, treatment planning and treatment of clients.

(b) A CIT should use methods or interventions that are generally accepted within the professional communities and literature, and should apply methods or interventions appropriate to the situations and characteristics of court-involved families.

(c) A CIT should be able to justify and explain the choice of methods based upon the current state of professional knowledge and research.

(d) The CIT should select treatment methods or approaches that minimize the potential for biased or inappropriate interpretations of client's statements and behaviors or perceptions of others' behavior. This may include deliberate balance in asking questions, challenging assumptions, and supplementing behavioral observations with other methods of inquiry.

(e) A CIT should exercise caution in forming opinions or structuring therapy based on limited or one-sided information.

(f) A CIT should maintain current knowledge about the validity (or lack of validity) of using specific behaviors as a basis for diagnosis or treatment, and should employ treatment methods that allow the therapist to gather information from a variety of methods and observations.

8.6 Critical examination of information

(a) A CIT should critically examine information received from a client before formulating or offering a clinical opinion. This is especially important in light of the possibility that a therapeutic alliance may produce a bias toward the client.

(b) A CIT should recognize that loss of therapeutic objectivity may harm a child or family, whether or not the therapist reports or testifies about the therapy. Therapists should avoid inappropriate bias by actively considering, and exploring, rival hypotheses about a client's difficulties.

8.7 A CIT should consider the clinical implications of actions taken when the CIT is asked to release treatment information, and should endeavor to minimize risks in these areas

(a) The therapist should be aware that an adult client requesting the release of information may not fully attend to, or understand, the risks and benefits of such a decision. This may lead to distress in the client or damage to the therapeutic alliance, if the client is surprised by the therapist's information or opinion.

(b) The therapist should assist the client in understanding:

(1) The risks and benefits of releasing information
(2) The nature of the information in the client's records
(3) The CIT's obligation to provide complete answers when questioned under oath and to avoid misleading other professionals or the Court
(4) Other potential factors that may lead to distress in the client or damage to the therapeutic relationship due to the release of information

(c) When a child is involved in treatment and the CIT is asked to release treatment information, the CIT should consider and address issues to minimize disruption of treatment and avoid distress in the child. Issues to consider may include:

(1) Appreciation of the parent's right to information and any concerns that he or she may have about the child or the therapy
(2) Protection of the child's treatment progress and privacy
(3) Potential for disruption of the therapeutic relationship if the parent feels excluded or resorts to litigation in order to obtain information
(4) Possibilities for negotiating the parent's involvement and managing the sharing of information without violation of the child's privacy, wholesale release of treatment information, or litigation

(d) The CIT should consider and address the various clinical possibilities in children's expressed preferences about disclosure of information. The CIT should consider the potential implications of whatever action the CIT takes, and should utilize available therapeutic options for dealing with the child's information. Issues to consider and address may include:

(1) Treatment goals related to the children's resolving of issues with parents
(2) A child's realistic or unrealistic fears about the parent's response to the information
(3) The child's own emotional issues or difficulty in expressing feelings directly

(4) Whether the child will ultimately be empowered or protected by having the CIT share information on the child's behalf
(5) Whether the child needs protective measures to prevent harm resulting from the sharing of therapeutic information
(6) Whether information can be disclosed in a therapeutic rather than legal setting

(e) The CIT should prepare both adult and child clients for the sharing of information and endeavor to anticipate any problems the client may experience as a result.

8.8 A CIT should seek appropriate advice

When in doubt about an appropriate course of action, the CIT should consider seeking legal advice or professional consultation. Such advice may protect both the clients/participants in therapy and the CIT.

GUIDELINE 9: DOCUMENTATION

9.1 A CIT should create documentation so that the Court can understand the treatment process, progress and financial arrangements

9.2 A CIT should establish and maintain a system of record keeping that is consistent with applicable law, rules, and regulations and that safeguards applicable privacy, confidentiality, and legal privilege. A CIT should create and maintain records reasonably contemporaneously with the provision of services.

(a) In deciding what to include in the record, the CIT may determine what is necessary in order to:

(1) Provide competent care
(2) Assist collaborating professionals in delivery of care
(3) Provide documentation required for reimbursement or required administratively under contracts or laws
(4) Effectively document any decision making, especially in high-risk situations
(5) Allow the CIT to effectively answer a legal or regulatory complaint

(b) If a client, parent or third party requests limited record keeping as a condition of treatment the CIT should explain that record keeping must meet professional standards.

9.3 Records should be organized and sufficiently detailed

A CIT should maintain records that facilitate the provision of future services by the CIT and by other professionals, ensure accuracy of billing and payments, and ensure compliance with ethical requirements and laws. Records should be sufficiently detailed, legible and readily available for reproduction upon receipt of appropriate releases or Court orders.

9.4 Confidentiality and security of records

A CIT should make all reasonable efforts to maintain confidentiality in creating, storing, accessing, transferring and disposing of records under his/her control. A CIT should maintain active control of records, provide appropriate training to any support staff, and take reasonable care to prevent the loss or destruction of records.

9.5 Ethical and statutory requirements

(a) A CIT should be cognizant of and follow relevant ethical and statutory requirements regarding maintaining records.

9.6 Communicate and clarify recordkeeping with the client and/or parents

(a) When the client is a child, the CIT should request any orders establishing who has the authority to consent to release of records. A minor may have the legal prerogative to consent to treatment, but the parent may nevertheless seek access to the records. A CIT should verify parents' statements of having the sole authority to consent to or block release of records by requesting relevant documents.

(b) When the CIT has multiple clients, such as when a parent participates in therapy with the child, the CIT should clarify as part of the informed consent procedure how the records are kept and who can authorize their release.

(c) A CIT should clarify any costs associated with providing copies of records and follow relevant statutes regarding fee arrangements. A CIT should not refuse to release records needed for emergency treatment because a client has not paid for services.

(d) Even when clients are participating in therapy pursuant to a Court order, the CIT should clarify policies, procedures and fees associated with the release of records and confidentiality.

GUIDELINE 10: PROFESSIONAL COMMUNICATION

Communication from a CIT to another therapist, the client, parents, counsel, or the Court carries with it an obligation to ensure that the communication is authorized, clear, and accurate. A CIT should recognize the adversarial nature of the legal system and the potential impact of the therapist's observations and opinions.

10.1 Authorization to communicate

A CIT should take reasonable steps to ensure that he/she is authorized to communicate with a third party, as described in Guideline 7.

10.2 Accuracy in communication

(a) In communication with others, a CIT should take reasonable steps to ensure that he/she is accurate in communicating:

(1) The nature of the service provided
(2) His or her opinions on diagnosis, prognosis, and/or progress in treatment
(3) His or her opinions on appropriate actions that would support the therapy
(4) His or her understanding of the role the therapist has with the family and in the Court process
(5) Reports or observations of parents' or children's behavior

(b) The CIT should make reasonable efforts to ensure that information regarding his or her services, including treatment, reports and testimony is communicated in language that can be understood by consumers and minimizes potential for misuse of the therapist's information.

10.3 Communicating limits and distinctions

A CIT should communicate the bases and limitations of observations and opinions.

(a) In all communications, especially in reports or testimony, the CIT should distinguish between observations, verbatim statements, inferences derived from his or her sources of information and conclusions or assessments reached.

(b) A CIT should articulate the limits of any communications. A CIT should decline to communicate opinions, recommendations, or information requested:

(1) When there is insufficient data on which to form a reliable opinion
(2) When there is no authorization to do so
(3) When the opinion requested is inconsistent with the role of the CIT

(c) Where the information available to the CIT might support more than one therapeutic assessment or opinion, the CIT should present and acknowledge the alternate possibilities and any treatment data or research supporting them.

(d) When necessary and appropriate, a CIT should be prepared to explain the limits of the CIT's role and the reasons it is inappropriate to give testimony or opinions in violation of that role.

10.4 Appropriate parties to include in communication

A CIT should carefully consider who should be aware of and involved in each professional communication.

(a) The CIT should consider whether one or both counsel, a guardian *ad litem*, child's counsel, other CITs, or parenting coordinator should be included in the communication.

(b) The CIT should respond with caution if an adult client's attorney requests a treatment report, particularly if the request comes through the client. The CIT should discuss with the client the potential content and implications of such a report, as discussed in Guidelines 7 and 8. With an appropriate release, the CIT may also wish to consider consulting with the adult client's attorney to ensure that the attorney is aware of the potential content and implications of a report from the therapist.

(c) The CIT in a neutral role, such as that of child's therapist, co-parenting therapist or conjoint/reunification therapist, should avoid unilateral communication with either parent's attorney in order to avoid appearance of bias and to contain the potential for actual bias.

10.5 Testimony

(a) A CIT should recognize the limits of his/her knowledge, and the potential impact that testifying in Court may have on the client and on treatment. Prior to testifying, a CIT should thoroughly discuss these issues with adult clients, and should engage in age-appropriate preparation of child clients.

(b) A CIT should comply with any limits on the scope of his/her testimony, which have been specified by a judicial officer in conjunction with any applicable ethical code.

(c) A CIT should anticipate that clients, attorneys, and the Court may ask the CIT to testify beyond the limits of his or her knowledge and role. The CIT should respectfully decline to provide information or opinions that exceed the treatment role or the CIT's knowledge base.

(d) A CIT should seek to clarify any conflicts between the testimony requested by the Court or counsel and any limitations imposed by professional ethics codes or licensing regulations.

(e) When the CIT is designated as an Expert Witness by the Court he or she may offer relevant clinical opinions within the role of the treating expert.

(1) The CIT may offer opinions on issues such as diagnosis, changes or behaviors observed in treatment, treatment plan, prognosis, coping and developmental abilities, conditions necessary for effective treatment, etc.
(2) The CIT should not render opinions on psycho-legal issues (e.g., parental capacity, child custody, validity of an abuse allegation, joint or sole custody), as these are beyond the scope of the treatment role and properly the province of other professionals and the Court

APPENDIX A

RESPONDING TO A SUBPOENA

This material is intended to supplement the information in Guidelines 7 and 8.7 regarding privilege and confidentiality issues, and the clinical management of requests for treatment records or information.

1. A subpoena is not a Court order. It is a formal request from an attorney to summon a witness or require a witness to bring documents to a hearing. The hearing might be a deposition (oral testimony taken under oath in preparation for a formal trial or to preserve the evidence) or a trial itself.

2. A CIT should never ignore a subpoena.

3. A CIT should not assume that a subpoena requires him or her to automatically disclose all requested information

4. Some jurisdictions have detailed statutes regarding psychotherapist privilege. These may include specific statutorily-mandated steps the CIT can take in response to receipt of a subpoena. In other jurisdictions, a CIT may want to obtain legal advice from an attorney familiar with (1) the privacy law in that jurisdiction; (2) the requirements specific to family court cases or the laws governing the CIT's role; and (3) the ethical obligations of mental health professionals. It is important for each CIT to know the state of the law in his or her jurisdiction on this issue and for the CIT to provide his/her counsel with any specific orders governing the CIT's role in the particular case.

5. The requirements for responding to a subpoena may be different in a juvenile or dependency court, a family court, a general civil court and a criminal court. When obtaining legal counsel with regard to a subpoena, the CIT should know which type of court is the setting for the case that generated the subpoena and should provide legal counsel with all relevant orders and documents.

6. If a CIT receives a subpoena regarding an adult client's treatment, he or she should make and document best efforts to notify the client or former client that the subpoena was served. The CIT should let the client know the scope of the information sought in the subpoena and that the client has a right to consult counsel to determine how best to respond to the subpoena.

7. If the subpoena was sent by the client's attorney, the CIT may, with the written consent of the client, cooperate with the attorney.

8. If the subpoena was sent by opposing counsel, the CIT may, with the written consent of the client, cooperate with the client's attorney to design a strategy for response to the subpoena.

9. In working with the client's attorney, it is important for the CIT to learn what the attorney hopes to gain from the CIT's involvement in (or exclusion from) the case, the issues being litigated, and the information and/or opinions that the lawyer will ask the CIT to reveal. The CIT should also attempt to learn what the opposing side is trying to achieve and whether and in what way the opposing lawyer may attempt to discredit the CIT's information and/or opinions.

10. Upon receipt of the subpoena, the CIT should carefully review his or her own records regarding the client and be prepared to discuss with the client and his or her attorney the following:

    A. Whether the record contains outdated material;
    B. Whether the record contains highly personal material;
    C. Whether the record contains information that could help the client achieve the goals described by the client's attorney;
    D. Whether the record contains information that could harm the client's goals.

11. If the subpoena was sent by the opposing attorney, the CIT should discuss with the client's attorney whether or not it would be useful to attempt to negotiate with opposing attorney to limit the scope of the subpoena, e.g., to redact outdated material, the names of third parties not important to the litigation or highly personal information.

12. The CIT should discuss with the client's attorney whether or not it would be wise to bring a Motion to Quash the subpoena, i.e., a request of the Court that the CIT be relieved of the obligation to provide testimony or produce records. The Motion to Quash must be grounded in some legally-cognizable rationale. For example, the material known to the CIT may not be relevant to the litigation. Or the opposition might be able to obtain the information known by the CIT from other sources, which would be less invasive to the client than obtaining information from the CIT. Or in some jurisdictions it will be possible to argue that, even though the CIT has information bearing on the case, it is more important that the client's privacy be maintained than that the information be disclosed.

13. If a child is the CIT's client and the child's records are subpoenaed, the CIT should consider whether or not the potential consequences to the child warrant opposing release of the information, requesting that an independent advocate be appointed, or warning the involved parties about risks to the child from release of the information. The CIT should be familiar with the procedures in his or her jurisdiction that are used to protect or consider the child's treatment information. In most jurisdictions, under ordinary circumstances, the parents or the person with legal custody of the child or the legal guardian has the power to determine whether or not to allow a child's private information to be released. However, if the parents are themselves in conflict in the litigation, the jurisdiction may have a special process for determining the child's privacy rights (as the parents are in a conflict of interest position about the child's privacy rights). Some jurisdictions will have a procedure by which a specially appointed person will decide,

after learning more about the litigation and the effects on the child, whether to waive or to assert the child's privilege. In some jurisdictions the decision of that appointee is decisive; in other jurisdictions, the person's decision is a recommendation to the Court, which has the final say.

14. If the CIT is asked to give information or an opinion about the effect on the child client of release of treatment information, the CIT should be prepared to explain the potential impact on the child of releasing the information and, conversely, the potential impact of withholding the information and the risks and benefits of each. Relevant factors might include the child's wishes, the impact of the decision on the child's ability to trust therapy and the CIT following a disclosure, the child's needs or ability to have his or her voice heard in the litigation, and whether or not there are other, less intrusive sources for obtaining the information.

15. The CIT should be aware that ultimate decisions regarding release of treatment information may not be the province of the therapist. Properly informed adults, and their attorneys, may have the right to control their treatment information. Those charged with protecting the child, such a minor's counsel, Guardian Ad Litem or the Court, may need to weigh and determine the best means of protecting the child's interests.

For supplemental information, please see the following documents:

Sample client-therapist contract:

http://www.afccnet.org/Portals/0/PublicDocuments/guidelines/Client-therapistcontract.pdf

Sample order for counseling:

http://www.afccnet.org/Portals/0/PublicDocuments/guidelines/OrderforCounseling.pdf

Sample stipulation and order for counseling:

http://www.afccnet.org/Portals/0/PublicDocuments/guidelines/StipulationandorderforCounseling.pdf

Suggested references:

http://www.afccnet.org/Portals/0/PublicDocuments/guidelines/Suggestedreferences.pdf

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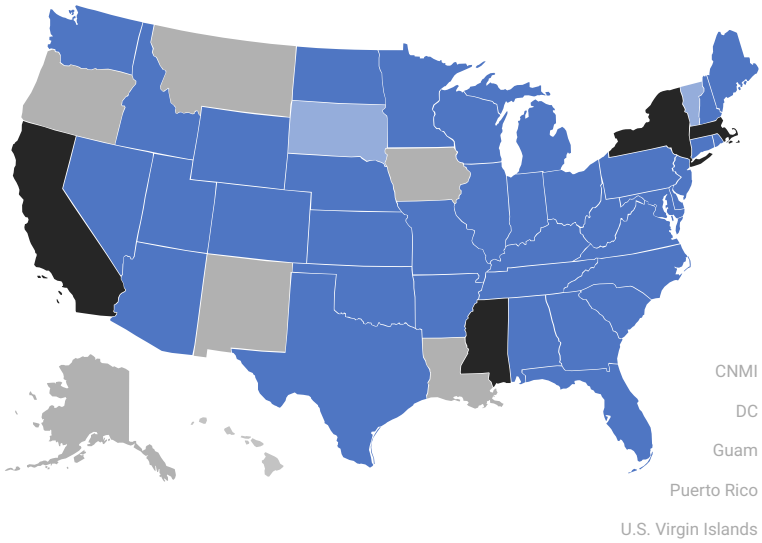

Map Key

- PSYPACT Participating State
- PSYPACT Legislation introduced
- Enacted PSYPACT Legislation - practice under PSYPACT not permitted
- Non- PSYPACT State/ no active Legislation

PSYPACT® PARTICIPATING STATES (41 ENACTED, 39 EFFECTIVE)

Alabama - AL SB 102 (Enacted 3/18/2021; Effective 6/1/2021)
Arizona - AZ HB 2503 (Enacted on 5/17/2016; Effective 7/1/2020)
Arkansas - AR HB 1760 (Enacted 4/25/2021; Effective (11/18/2021)
Colorado - CO HB 1017 (Enacted 4/12/2018; Effective 7/1/2020)
Commonwealth of the Northern Mariana Islands - CNMI HB 22-80 (Enacted and Effective 10/24/2022)
Connecticut -CT S 2(Enacted 5/24/2022; Effective 10/1/2022)
Delaware - DE HB 172 (Enacted 6/27/2019; Effective 7/1/2020)
District of Columbia - DC B 145 (Enacted and Effective 4/2/2021)
Florida -FL H 33(Enacted 5/25/2023; Effective 7/1/2023)
Georgia - GA HB 26 (Enacted 4/23/2019; Effective 7/1/2020)
Idaho - ID S 1305 (Enacted 3/23/2022; Effective 7/1/2022)
Illinois - IL HB 1853 (Enacted 8/22/2018, Effective 7/1/2020)
Indiana -IN S 365(Enacted 3/10/2022; Effective 7/1/2022)
Kansas - KS SB 170 (Enacted 5/17/2021; Effective 1/1/2022)
Kentucky - KY HB 38 (Enacted 3/18/2021; Effective 6/28/2021)
Maine - ME HB 631 (Enacted 6/22/2021; Effective 10/18/2021)
Maryland - MD HB 970 (Enacted and Effective 5/18/2021)
Michigan -MI H 5489(Enacted 12/22/2022; Effective 3/29/2023)
Minnesota - MN SB 193 (Enacted 5/25/2021; Effective 5/26/2021)
Missouri - MO HB 1719/MO SB 660 (Enacted 6/1/2018; Effective 7/1/2020)
Nebraska - NE L 1034 (Enacted 4/23/2018; Effective 7/1/2020)
Nevada - NV AB 429 (Enacted on 5/26/2017; Effective 7/1/2020)
New Hampshire- NH SB 232 (Enacted 7/10/2019; Effective 7/1/2020)
New Jersey -NJ A 4205(Enacted 9/24/2021; Effective 11/23/2021)

North Carolina - NC 361 (Enacted 7/1/2020; Effective 3/1/2021)
North Dakota - ND S 2205 (Enacted 4/13/2023; Effective 8/1/2023)
Ohio -OH S 2 (Enacted 4/27/2021; Effective 7/26/2021)
Oklahoma - OK HB 1057 (Enacted 4/29/2019; Effective 7/1/2020)
Pennsylvania- PA SB 67(Enacted 5/8/2020; Effective 7/8/2020)
Rhode Island -RI H 7501(Enacted 6/21/2022; Effective7/1/2023)
South Carolina -SC H 3204(Enacted 5/16/2023; Effective7/17/2023)
Tennessee -TN S 161 (Enacted and Effective 5/11/2021)
Texas - TX HB 1501 (Enacted 6/10/2019; Effective 7/1/2020)
Utah - UT SB 106 (Enacted on 3/17/2017; Effective 7/1/2020)
Virginia- VA SB 760(Enacted 4/11/2020; Effective 1/1/2021)
Washington -WA H 1286(Enacted 3/4/2022; Effective 6/9/2022)
West Virginia - WV SB 668 (Enacted 4/21/2021; Effective 11/18/2021)
Wisconsin -WI A 537 (Enacted 2/4/2022; Effective 2/6/2022)
Wyoming - WY S 26 (Enacted 2/15/2023; Effective 2/15/2023)

ENACTED, NOT YET EFFECTIVE

Vermont - VT H 282 (Enacted 6/1/2023; Effective 7/1/2024)
South Dakota - SD H 1017 (Enacted 2/13/24: Effective 7/1/2024)

ENACTED, UNDER FURTHER REVIEW

(* indicates PSYPACT legislation has been enacted in a state but has not been formally adopted by the PSYPACT Commission. PSYPACT authorizations are not yet valid in this state.)
N/A

ACTIVE PSYPACT LEGISLATION

*(*Please note the following states have introduced PSYPACT legislation but have not yet enacted PSYPACT and therefore are not considered PSYPACT participating states.)*

Introduced in 2023:

Massachusetts -MA S1980 and MA H2986

New York -NY S6883, NYA07947 and NYA9406

Introduced in 2024:

California -AB-2051

Mississippi -SB 2157

PREFILED LEGISLATION

(*Please note the following states have pre-filed legislation to be heard during the upcoming legislative session.)*

N/A

Non- PSYPACT States/Jurisdiction

*(*Please note the following states/jurisdiction have not enacted PSYPACT legislation nor do they have active PSYPACT legislation)*

Alaska
Guam
Iowa
Hawaii
Louisiana
Montana
New Mexico
Oregon
Puerto Rico
U.S. Virgin Islands

PSYPACT LEGISLATIVE UPDATE

What happens after a state enacts PSYPACT? Click **HERE** to learn more.

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Substance Use and Parenting

Best Practices for Family Court Practitioners

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

ASSOCIATION OF FAMILY AND CONCILIATION COURTS
Massachusetts AFCC

June 2021

TABLE OF CONTENTS

Acknowledgements

This guidebook is available without charge due to the limited resources that exist on this topic and urgent need for evidence-based information to support affected children and families. The editor and contributors agreed at the outset of this project that cost should not be a barrier for information. It is our hope that this publication is shared widely.

There are many people who helped to bring this book to fruition. I would like to start off by giving a special thank you to Jordana Douglas for the countless hours she spent reading and providing feedback on the numerous drafts of the book and for her thoughtful comments throughout the writing and editing process. She was integral to this project. Great things are ahead for you, Jordana – the sky is the limit. A special thank you to Donna Feinberg and Patricia Brady, who invited me to work on this project. Both viewed expanding evidence-based knowledge about addiction as critically important. Many thanks to those who took time out of their busy lives to read full drafts of the book and provided thoughtful, helpful feedback: Judge Beth Crawford, Judge Thomas Barbar, Judge Christina Harms, Jennifer Clapp, Payal Ravani, Abigail Judge, and Tony Pelusi.

One aspect of the book that is particularly special is that it was a true interdisciplinary endeavor. Each chapter in the book was reviewed by a mental health professional and an attorney. Thank you to the many chapter editors: Lisa Gallagher, Mira Levitt, Alicia Doherty, Stephen Burns, Kelly Flynn, Graham Garwood, Kathleen Michaud, Joanne Romanow, and Harry Somers.

Lastly, my sincere gratitude to the people I have worked with over the years with substance use disorders. I have learned from each of you and this book would not exist without you. Thank you.

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

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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

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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

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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

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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

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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

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"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

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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

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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

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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

_____

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

_____
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.

June 2021


ASSOCIATION OF FAMILY AND CONCILIATION COURTS
Massachusetts
AFCC

THEIMANN
ADVISORY
School of Social Work
University of North Carolina at Chapel Hill

Tina Souders, MSW, JD
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David DeVito, MSW

June 2009

FAQ on Services to Minors of Divorced Parents

Introduction

Theimann Advisories are periodic commentaries on the ethical, legal, and clinical implications of complex service dilemmas. They are issued with the support of the Smith P. Theimann, Jr. Distinguished Professorship in Ethics and Professional Practice and are distributed to alumni, students, and field instructors affiliated with the UNC Chapel Hill School of Social Work, as well as to the broader community of service providers.

Advisories use laws, ethics, and professional standards to craft recommendations in response to specific practice questions. They are intended to provide general guidelines for practice, but are not a substitute for legal advice or professional consultation and supervision on specific case matters. This Advisory utilizes North Carolina statutes in examining the issues presented. As such, some advice may not translate to other jurisdictions. Changes in laws, regulations and practice guidelines that occur after the advisory is issued may also affect the relevance of the recommendations.

This Advisory addresses the challenges presented in providing mental health or counseling services to minor clients whose parents are divorced or separated. It is intended to apply to the array of helping professionals, including social workers, counselors, and psychologists in a variety of child and adolescent service settings. Any meaningful distinctions among settings or types of professionals will be noted in the Advisory.

Understanding Custody

All states have statutes addressing custody of minor children. Few, however, define the terms used in discussing this issue. North Carolina is no different in this regard. The common understanding of "custody of a minor" refers to all the obligations and rights associated with the care, protection and control over the minor child.

The law uses the term "legal custody" to refer to the rights and obligations associated with making significant decisions affecting the child's life. These typically relate to health, schooling, religious instruction and other issues with long-term implications for the child. If one parent has the right to make all major decisions for the child that parent is commonly understood to have sole legal custody. If both parents share the right to make major decisions, or if certain decisions are divided between them, then it is assumed both parents have joint legal custody. The parent(s) with legal custody has the right to make these decisions even if financial support comes from somewhere else (Lee's North Carolina Family Law, §13.2b).

"Physical custody" refers to the obligations and rights of the person with whom the child resides. The parent with physical custody has the right to supervise the child, however decision making is limited to matters associated with the child's routine needs. Decisions such as where the child will attend school or what significant medical treatment the child might undergo typically have long-term consequences and therefore may only be made by the parent with legal custody. If the minor child resides with only one parent for significant periods of time then that parent is referred to as having primary physical custody or sole physical custody (Lee's North Carolina Family Law, §13.2c).

The standard used by the courts for determining custody of the minor child during divorce and separation proceedings is "the best interest of the child" (Lee's North Carolina Family Law, §50-13.2). "In North Carolina and in every state, a court may modify its order on the custody of a minor upon a change of circumstances affecting the welfare of the child" (Lee's North Carolina Family Law, §13.98a pg. 13-177). Parents are able to modify a court order regarding custody. To do so, courts require that there has been a substantial change of circumstances that affects the minor child and that modification is in the best interest of the child (Lee's North Carolina Family Law, §13.99). Thus, parents cannot seek modifications for trivial matters, but might so do if, for example, one parent was required to pay for medical expenses but then lost his/her job, or if the custodial parent became ill and was unable to fulfill that role as expected.

Since statutory law in North Carolina is silent on terms related to custody, this often contributes to problems when courts, lawyers, and custody orders fail to explain the agreements made between the parents. It is good practice that rights and responsibilities of each parent are clearly delineated in custody orders and that terms, such as joint custody, are fully explained. In fashioning a custody order, the court may also include a mechanism for resolving disagreements between parents with joint legal custody. In some jurisdictions, an "allocated parenting" agreement may be drafted to specify the rights and responsibilities between two competent but conflict-prone parents. These documents specify responsibility for significant events (visitation for holidays, payment of medical or dental expenses) as well as benign, but common, areas of dispute (payment for school clothes, field trips, summer camp, sports teams). Such "parallel parenting" arrangements anticipate disputes and attempt to address them proactively, removing children, therapists, health care providers, and others from conflicts between former spouses.

Frequently Asked Questions

1. If a parent brings a minor in for counseling, must the clinician/agency inquire about the presence of another parent and that person's consent for treatment? Does this change if payment/insurance is in the name of another adult?

Under North Carolina Law (GS 32A-30) the consent of one custodial parent would suffice, however practice advice suggests that the consent of both parents should be sought at the outset of (or before) treatment. Even though a non-custodial parent's consent is legally immaterial (DeKraai & Sales, 1991; Lawrence & Kurpius, 2000), it may still be ethically and clinically advisable to seek that person's assent (agreement) to treatment (Koocher, 2007).

Seeking consent of both parents serves a number of functions. It preemptively identifies disagreements between the parents about the nature of the child's difficulties and need for treatment. This information may prove relevant for case assessment and treatment planning. The transparency in involving both parents fulfills the ethical principles of veracity and fidelity (truthfulness and trustworthiness) and reduces the likelihood that the child or therapist will be triangulated between the parents.

Contacts with estranged or angry ex-spouses may be uncomfortable for all involved (and may be resisted by the parent presenting for service). Yet as Koocher suggests, "A parent who truly seeks to serve only the best interests of the child will not object to allowing contact with the other parent or to providing necessary documentation" to facilitate contact (2007, p. 12). Alternatively, the clinician may recommend that the presenting, custodial parent converse with the other parent about the decision to seek treatment in lieu of the clinician pursuing contact and securing permission.

Neither scenario is easy: work with minors of divorced or separated parents clearly lies as much in the field of family therapy as it does in specialty of child and adolescent treatment. Obtaining the consent of both parents involves navigating emotionally-charged and history-laden territory. Clinical resources can provide guidance about the dynamic issues following

marital dissolution and reintegration and the steps for helping parents come to terms with these challenges for the benefit of their children (Blow & Daniel, 2002; Visher & Visher, 1989).

Should the clinician decide to render treatment based solely upon one custodial parent's permission, he or she should discuss the possible repercussions of this stance with the parent (and the minor client, if age-appropriate). For example, if the parent with shared custody finds out about the treatment and objects to it, what steps must be taken? What will the agency disclose if the other parent seeks information about the care of the child, after discovering treatment absent his or her consent? These scenarios are addressed below, but their likelihood of occurring can be diminished if mutual consent is sought up front.

In any of these cases, the clinician should be certain to document the conversation and resulting decisions in the client's case record. Sound ethical decision making would also suggest that the worker discuss it with a supervisor, consultant, or knowledgeable colleague and document those findings as well (Strom-Gottfried, 2007)

A parent's obligation to pay a dependent's medical expenses is established as part of the divorce proceedings and is typically recorded in an order or agreement. The responsibility for payment is separate from custody and the capacity to give consent. Under an agreement of support, the custodial parent's authorization for service is valid by law. GS 50-13.11 outlines the procedures for the provision of health care and health insurance to minors. Either the court will assign the responsibility to one of the parents, or the parents enter into an agreement for medical support. According to sub-chapter (d), "When a court order or agreement for health insurance is in effect, the signature of either party shall be valid authorization to the insurer to process an insurance claim on behalf of a minor child." (see GS 50-13.11 below)

Although a non-custodial parent's consent for service is irrelevant, even if he or she is required to pay for the service, the clinician should still determine that person's role at the outset of treatment. As suggested above, informing this individual of the services and soliciting this person's assent for the treatment seems both ethically fair and clinically sound.

2. What obligation does the agency have to secure documentation that verifies custody status? How frequently should the agency request documentation? What type of documentation is sufficient?

Prudent practice suggests that the agency seek a copy of all materials related to the child's legal status. In cases of divorce, this would include obtaining a copy of the divorce decree (Carmichael, 2006) or "order of custody" and including it in the patient's record. Because circumstances can change (remarriage, job loss, relocation, etc) and parents can seek to alter an order, agencies should have a recommended schedule by which copies of orders are routinely sought (every six months, for example). In addition, if the clinician is aware of changes in family circumstances, he or she should seek copies of new orders outside that schedule as warranted.

3. How is informed consent executed with the other parent?

Ideally, the clinician would meet with the parents in person, individually or jointly to discuss the purpose, risks and costs of services, and available alternatives. The clinician should also describe the parents' rights to withhold or withdraw consent and any consequences of doing so (for example, implications for the child's condition, reports back to referring agencies, etc.). This information should be rendered in clear and understandable language, and reiterated as necessary throughout the treatment process. In addition to securing verbal consent, a formal, standardized informed consent document should be signed by both parents (Carmichael, 2006; DeKraai & Sales, 1991; Lawrence & Kurpius, 2000).

Typical informed consent conversations include discussions about the limits of confidentiality (suspected abuse, danger to self or other) and the clinician's policies on sharing content from counseling sessions with the client's parents. In cases involving divorced or estranged parents informed consent should also address the clinician's stance on sharing information with the other custodial parent. The obligation to share information with another custodial parent is addressed elsewhere in this Advisory.

In regard to non-custodial parents, the clinician's obligations are less clear. Some jurisdictions or divorce decrees might specify that parent's right to information. In other instances, the parent's access would be determined by the provider's preferences and the facts of the case. As such, the therapist may be willing to offer the non-custodial parent full, limited, or no access to case information. The important point is that the parameters should be made clear to all parties as part of the informed consent process and their agreement to that plan secured.

Because of distance and other factors, face-to-face meetings are sometimes impractical or impossible to arrange. The alternatives in this case include one-on-one phone conversations, a conference call with both parties, or letters to the parents. Verbal interactions clearly offer the opportunity for greater depth of explanation, and opportunities for questions and answers and for testing understanding of information shared. These correspondences can reference a written consent form which should be signed and returned to the agency.

4. What difference does it make if the parents have joint custody or one has sole custody?

If one parent has sole legal custody, then consent of that parent alone is sufficient for treatment. It is not necessary to seek consent from the other parent as that parent does not have legal decision making ability, however as discussed above, it may be clinically appropriate to seek the consent of both. If the parents have joint legal custody, then either parent may consent, but again, involving both adult figures may have therapeutic benefits and avoid disruptions later in the process.

5. What are the clinician's responsibilities in situations where both parents have legal custody but one parent consents to treatment and one refuses (for example, on the basis of cost or disputations about the need for or value of counseling)?

If the clinician agrees that treatment is unnecessary he or she can refuse to treat, explain and document the rationale, and suggest mechanisms by which the parents can more effectively resolve their differences about the care of their children. In the more common scenario, the clinician concurs with the need for treatment and thus is faced with a potential conflict of interest, in which advocating for treatment (ostensibly with him/her) is in his or her self interest and also allies the clinician with one parent and against another, when the cooperation of both is usually needed for the benefit of the child.

One way out of this entanglement is for the helping professional to address the parents' dispute as a singular goal for work. Should the parties be able come to an agreement to proceed with therapy for the child, that service would be provided by another professional or agency. Assisting an estranged couple to effectively communicate and create processes for addressing their children's needs is a worthwhile clinical objective in its own right, not simply an instrumental step to facilitate service to the child (Blow & Daniel, 2002; Visher & Visher, 1989).

Should the parents' impasse prove to be intractable, three further options exist. One would be for the parents to litigate the dispute so that a court stipulates parental rights as part of revised orders governing their custody arrangements and responsibilities. The disadvantages of this step are the cost, time involved and the perpetuation (and perhaps entrenchment) of existing conflict. In some cases, a court may intervene to force treatment against a custodial parent's wishes (Feigenbaum, 1991-1992). Courts may intervene over the objections of parents when the consequences of failing to provide treatment are severe and the treatment sought involves little risk to the child. (Lee's North Carolina Family Law, §50-15.29 f). Numerous court cases have upheld the court's authority to order medical treatment when a parent unreasonably withholds consent though these cases typically concern invasive medical procedures that substantially affect the child's health or safety, rather than less urgent matters of mental health or other forms of counseling. In processes such as this, a petition is filed for a judicial finding that the child is neglected or dependant and a guardian ad litem is appointed to represent the minor's interests "in any proceeding, formal or informal" (Feigenbaum, 1991-1992, p. 843). This helps assure that the child's needs are not subordinated to the parent's enmity for each other or their individual interests.

Options to adjudication include alternative dispute resolution (ADR) processes such as arbitration or mediation in which the parents would work with an individual trained to help the parties air their differences, hear the others' perspective, and reach a mutually agreeable conclusion. In some instances, arbitration is binding, and in those, the decision of the arbitrator, not the individuals, would take precedence. While ADR is less adversarial than adjudication of grievances, it can be time consuming, and must be carefully constructed so that the less powerful or vocal party is not disadvantaged in negotiations or compromise. In some high-conflict divorces, the involvement of a guardian ad litem (GAL) may be mandated by the court. In this event, the GAL would be an appropriate resource for arbitration or mediation of this and other areas of disagreement.

As a final option to parental disputes about minor's care, the case could be referred to child welfare authorities for determination of medical neglect. Chapter 7B of the NC General Statutes outlines the policies and procedures for adjudication of cases of juvenile abuse, neglect, and dependency. The code includes in the definition of a neglected juvenile any minor "who is not provided necessary medical care; or who is not provided necessary remedial care" (NC GS § 7B-101.

Definitions). Cases of neglect may also connote abuse if the responsible adult "creates or allows to be created serious emotional damage to the juvenile;" which is "evidenced by a juvenile's severe anxiety, depression, withdrawal, or aggressive behavior toward himself or others" (NC GS § 7B-101. Definitions). Cases of abuse may be pursued by law enforcement, and entail criminal proceedings.

It is wise to seek consultation from experts in child welfare and/or child protective service personnel prior to making a referral on the basis on medical neglect. While such referral may in some instances be clearly necessary for the worker to fulfill his or her role as a mandated reported, ambiguous or punitive referrals by professionals (or a disaffected parent) will likely escalate conflict and alienation rather than a resolution that is ultimately helpful to the child.

6. What if the parent presenting for service explicitly requests that the other parent not be contacted because of some compelling reason (a history of explosive anger, abuse, instability, or paranoia)?

There may indeed be situations in which it is impractical, unsafe, or unsound to involve a noncustodial parent in assenting to the child's treatment. If the reasons for excluding the other parent are formally documented (for example, incarceration or termination of parental rights) "the word of one parent should require corroboration (e.g. a confirmatory letter from a member of the bar or a copy of a court order)" (Koocher, 2007, p.12). If the concerns have not been formally established, the clinician should explore the basis for the presenting parent's apprehensions, any substantiation for the parent's claims, the nature and scope of the anticipated services, and the implications of serving the child without informing the other parent. The clinician should seek consultation about the implications of proceeding with treatment and review those with the presenting parent. For example, what are the likely repercussions (for the child client and others) if the noncustodial parent learns of the treatment and demands access to records or other information about the care provided? If the clinician ultimately determines that consulting with both parents is contraindicated (or that one parent should be denied access to records) the clinician should document the steps taken to reach this decision and the information supporting it.

7. What responsibility does the agency have to share information with the other parent if he/she seeks information about the status of that child's care? Does this obligation differ if the parent requesting information is non-custodial?

According to Corbet (2006) divorced parents have equal access to their child's record unless a court order specifies differently. GS 50-13.2 reads, "Absent an order of the court to the contrary, each parent shall have equal access to the records of the minor child involving the health, education, and welfare of the child." Therefore both parents have equal rights to the medical records upon request, barring any other scenarios that would preclude disclosure (i.e., when the disclosure serves the parent's interest and is not in the best interest of the child). It is important though, to differentiate the right of access from the right to give consent. While access to records may be available upon request, a parent without legal custody may not consent to significant medical/psychiatric treatment.

The NASW Code of Ethics (2008) stipulates that "social workers should provide clients with reasonable access to records concerning the clients. Social workers who are concerned that clients' access to their records could cause serious misunderstanding or harm to the client should provide assistance in interpreting the records and consultation with the client regarding the records. Social workers should limit clients' access to their records, or portions of their records, only in exceptional circumstances when there is compelling evidence that such access would cause serious harm to the client. Both clients' requests and the rationale for withholding some or all of the record should be documented in clients' files"(1.08).

While the Code does not differentiate minor's records from those of adult clients, the guidance provided about access, limits, and documentation of related decisions is germane to minors' records and parental access.

8. If a grandparent (or other non-parent relative) brings a minor in for counseling, must the clinician/agency inquire about the parent? What if the parent is incarcerated, resides in another state, is hospitalized or otherwise unavailable?

GS 32A Article 4 (see Appendix below) outlines procedures for "delegating the decisions to health care for the parent's minor child when the parent is unavailable for a period of time by reason of travel or otherwise." In the following section we discuss the conditions under which services should be rendered without a parent's consent. In instances other than those described below, it seems unwise to serve a minor on an extended basis without parental permission, even though the minor may be presented for service by a relative or other responsible adult.

This is clearly an ethical dilemma, in that the duty to serve, especially in a compelling case of a distraught or needy minor, is in conflict with a parent's right to approve or disapprove of non-emergency services for his or her child. A clinician or agency may bridge this divide by providing circumscribed and time-limited assistance in the case, for example, meeting with the minor and presenting adult in order to assess the situation, rule out emergent circumstances, and advise the adult on steps to secure custody. Assisting the adult may include providing a list of attorneys who could help with custody proceedings, consulting with child welfare authorities about their jurisdiction or assistance in the case, and exploring with the adult the assistance and documentation needed to carry out other responsibilities for the minor. If the provider believes that more extensive involvement is warranted without parental permission, he or she should seek legal, ethical and clinical consultation about the impetus for this decision and other available options. Possible consequences for agencies or individuals who provide non urgent services without parental consent include complaints to licensure or regulatory authorities and civil actions.

9. In what situations can treatment be given to minors without parental consent?

Jill Moore (2005) notes five situations mentioned in the General Statutes which constitute exceptions to the parental consent mandate. 1) Parent authorizes another adult to give consent [GS 32A-Article 4]; 2) Emergencies and other circumstances [GS 90-21.1]; 3) Immunizations: A physician or local health department may immunize a minor who is presented for immunization by an adult who signs a statement that he or she has been authorized by the parent, guardian, or parent in loco parentis, to obtain the immunization for the minor [GS 130A-153(d)]; 4) Emancipated minors [GS 90-21.5]; 5) Minor's consent law [GS 90-21.5] allows physicians to accept unemancipated minors' consent for treatment for the prevention, diagnosis, or treatment of venereal and other reportable communicable diseases, pregnancy, abuse of controlled substances or alcohol, or emotional disturbance. Exceptions to the rule include: sterilization, abortion, or admission to a 24-hour mental health or substance abuse facility (except in an emergency). Note: a health care provider must not accept a person's consent to treatment without evidence of decisional capacity to do so. Thus the consent must be voluntary, knowing and competent (Sales, DeKraai, Hall, & Duval, 2008).

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Appendices

Emancipation in NC - (Corbet, 2006)

- Emancipation by petition (over age 16), or by marriage (as young as 14). Parental consent is required for 14-15 year-olds to marry.

North Carolina General Statutes
Chapter 90 (Medicine and Allied Occupations)
DeVito's note: There's language in this chapter that addresses some of the consent questions; however, the articles seem to be aimed (and limited?) to the practice of medicine. I'm not certain that either of these articles apply to counselors.

§ 90-21.1. When physician may treat minor without consent of parent, guardian or person in loco parentis.

It shall be lawful for any physician licensed to practice medicine in North Carolina to render treatment to any minor without first obtaining the consent and approval of **either** the father or mother of said child, or any person acting as guardian, or any person standing in loco parentis to said child where:

(1) The parent or parents, the guardian, or a person standing in loco parentis to said child cannot be located or contacted with reasonable diligence during the time within which said minor needs to receive the treatment herein authorized, or

(2) Where the identity of the child is unknown, or where the necessity for immediate treatment is so apparent that any effort to secure approval would delay the treatment so long as to endanger the life of said minor, or

(3) Where an effort to contact a parent, guardian, or person standing in loco parentis would result in a delay that would seriously worsen the physical condition of said minor, or

(4) Where the parents refuse to consent to a procedure, and the necessity for immediate treatment is so apparent that the delay required to obtain a court order would endanger the life or seriously worsen the physical condition of the child. No treatment shall be administered to a child over the parent's objection as herein authorized unless the physician shall first obtain the opinion of another physician licensed to practice medicine in the State of North Carolina that such procedure is necessary to prevent immediate harm to the child.

Provided, however, that the refusal of a physician to use, perform or render treatment to a minor without the consent of the minor's parent, guardian, or person standing in the position of loco parentis, in accordance with this Article, shall not constitute grounds for a civil action or criminal proceedings against such physician. (1965, c. 810, s. 1; 1977, c. 625, s. 1.)

§ 90-21.5. Minor's consent sufficient for certain medical health services.

(a) Any minor may give effective consent to a physician licensed to practice medicine in North Carolina for medical health services for the prevention, diagnosis and treatment of (i) venereal disease and other diseases reportable under G.S. 130A-135, (ii) pregnancy, (iii) abuse of controlled substances or alcohol, and (iv) emotional disturbance. This section does not authorize the inducing of an abortion, performance of a sterilization operation, or admission to a 24-hour facility licensed under Article 2 of Chapter 122C of the General Statutes except as provided in G.S. 122C-222. This section does not

prohibit the admission of a minor to a treatment facility upon his own written application in an emergency situation as authorized by G.S. 122C-222.

(b) Any minor who is emancipated may consent to any medical treatment, dental and health services for himself or for his child. (1971, c. 35; 1977, c. 582, s. 2; 1983, c. 302, s. 2; 1985, c. 589, s. 31; 1985 (Reg. Sess., 1986), c. 863, s. 4.)

Chapter 32A – Powers of Attorney

§ 32A-28. Purpose.

(a) The General Assembly recognizes as a matter of public policy the fundamental right of a parent to delegate decisions relating to health care for the parent's minor child where the parent is unavailable for a period of time by reason of travel or otherwise.

(b) The purpose of this Article is to establish a nonexclusive method for a parent to authorize in the parent's absence consent to health care for the parent's minor child. This Article is not intended to be in derogation of the common law or of Article 1A of Chapter 90 of the General Statutes. (1993, c. 150, s. 1.)

§ 32A-29. Definitions.

As used in this Article, unless the context clearly requires otherwise, the term:

(1) "Agent" means the person authorized pursuant to this Article to consent to and authorize health care for a minor child.

(2) "Authorization to consent to health care for minor" means a written instrument, signed by the custodial parent and acknowledged before a notary public, pursuant to which the custodial parent authorizes an agent to authorize and consent to health care for the minor child of the custodial parent, and which substantially meets the requirements of this Article.

(3) "Custodial parent" means a parent having sole or joint legal custody of that parent's minor child.

(4) **"Health care" means any care, treatment, service or procedure to maintain, diagnose, treat, or provide for a minor child's physical or mental or personal care and comfort, including life sustaining procedures and dental care.**

(5) "Life sustaining procedures" are those forms of care or treatment which only serve to artificially prolong life and may include mechanical ventilation, dialysis, antibiotics, artificial nutrition and hydration, and other forms of treatment which sustain, restore, or supplant vital bodily functions, but do not include care necessary to provide comfort or to alleviate pain.

(6) "Minor or minor child" means an individual who has not attained the age of 18 years and who has not been emancipated. (1993, c. 150.)

§ 32A-30. Who may make an authorization to consent to health care for minor.

Any custodial parent having understanding and capacity to make and communicate health care decisions who is 18 years of age or older or who is emancipated may make an authorization to consent to health care for the parent's minor child. (1993, c. 150, s. 1.)

§ 32A-34. Statutory form authorization to consent to health care for minor.

The use of the following form in the creation of any authorization to consent to health care for minor is lawful and, when used, it shall meet the requirements and be construed in accordance with the provisions of this Article.

"Authorization to Consent to Health Care for Minor."

I, _____, of _____ County, _____, am the custodial parent having legal custody of_____, a minor child, age_____, born_____, ____ . I authorize_____, an adult in whose care the minor child has been entrusted, and who resides at_____, to do any acts which may be necessary or proper to provide for the health care of the minor child, including, but not limited to, the power (i) to provide for such health care at any hospital or other institution, or the employing of any physician, dentist, nurse, or other person whose services may be needed for such health care, and (ii) to consent to and authorize any health care, including administration of anesthesia, X-ray examination, performance of operations, and other procedures by physicians, dentists, and other medical personnel except the withholding or withdrawal of life sustaining procedures.

[Optional: This consent shall be effective from the date of execution to and including_____,_____].

By signing here, I indicate that I have the understanding and capacity to communicate health care decisions and that I am fully informed as to the contents of this document and understand the full import of this grant of powers to the agent named herein.

(SEAL)
Custodial Parent Date

STATE OF NORTH CAROLINA

COUNTY OF

On this _____ day of_____, ____, personally appeared before me the named_____, to me known and known to me to be the person described in and who executed the foregoing instrument and he (or she) acknowledges that he (or she) executed the same and being duly sworn by me, made oath that the statements in the foregoing instrument are true.

Notary Public

My Commission Expires:

(OFFICIAL SEAL). (1993, c. 150, s. 1; 1999-456, s. 59.)

§ 50-13.11. Orders and agreements regarding medical support and health insurance coverage for minor children.

(a) The court may order a parent of a minor child or other responsible party to provide medical support for the child, or the parties may enter into a written agreement regarding medical support for the child. An order or agreement for medical support for the child may require one or both parties to pay the medical, hospital, dental, or other health care related expenses.

(a1) The court shall order the parent of a minor child or other responsible party to maintain health insurance for the benefit of the child when health insurance is available at a reasonable cost. If health insurance is not presently available at a reasonable cost, the court shall order the parent of a minor child or other responsible party to maintain health insurance for the benefit of the child when health insurance becomes available at a reasonable cost. As used in this subsection, health insurance is

considered reasonable in cost if it is employment related or other group health insurance, regardless of service delivery mechanism. The court may require one or both parties to maintain dental insurance.
(b) The party ordered or under agreement to provide health insurance shall provide written notice of any change in the applicable insurance coverage to the other party.
(c) The employer or insurer of the party required to provide health, hospital, and dental insurance shall release to the other party, upon written request, any information on a minor child's insurance coverage that the employer or insurer may release to the party required to provide health, hospital, and dental insurance.
(d) When a court order or agreement for health insurance is in effect, the signature of either party shall be valid authorization to the insurer to process an insurance claim on behalf of a minor child.
(e) If the party who is required to provide health insurance fails to maintain the insurance coverage for the minor child, the party shall be liable for any health, hospital, or dental expenses incurred from the date of the court order or agreement that would have been covered by insurance if it had been in force.
(f) When a noncustodial parent ordered to provide health insurance changes employment and health insurance coverage is available through the new employer, the obligee shall notify the new employer of the noncustodial parent's obligation to provide health insurance for the child. Upon receipt of notice from the obligee, the new employer shall enroll the child in the employer's health insurance plan. (1989 (Reg. Sess., 1990), c. 1067, s. 1; 1991, c. 419, s. 2; c. 761, s. 42; 1997-433, s. 3.1; 1998-17, s. 1; 2003-288, s. 3.2.)