



**Center for
Advancing Justice**

How to Address Substance Use From the Bench

A FAMILY COURT DOCKET BENCH CARD

Introduction

This bench card addresses parental substance use disorders (SUDs) in child welfare cases. It supplements but does not replace comprehensive abuse and neglect guides and benchbooks. Each case requires individualized inquiry consistent with state or tribal statutes, timelines, and the child's developmental needs.

Key Principles

- **Understand that SUD is a chronic, relapsing brain disease.** Recurrence does not equal failure.
- **Make sure there is a nexus.** A parent's substance use or return to use, standing alone, is generally not sufficient to remove children from the home; there must be a connection to child abuse/neglect.
- **Look for progress, not perfection.** Assess parental engagement and meaningful change, not just compliance.
- **Distinguish symptoms from willful noncompliance.** Missed appointments, return to use, or defensiveness may reflect SUD symptoms, not intentional refusal to engage.
- **Maintain the parent-child bond through regular contact.** Visitation conditions should be based on assessed safety risk, not solely on drug test results.

Supervision may be appropriate when there are specific safety concerns about the parent's ability to protect the child during unsupervised visits.

- **Balance timelines.** Permanency timelines must be balanced with realistic recovery progress, with extensions for good cause considered when possible.
- **Evidence-based services matter.** Ensure prompt access to appropriate, accessible treatment at the assessed level of care.
- **Require an individualized assessment.** Each family needs individualized inquiry and planning.

Many parents successfully recover from SUD and safely reunite with their children. The goal is to assess capacity and progress accurately, not to punish individuals for having a disease.

Focus of Judicial Inquiry by Stage

The judicial inquiry should evolve as the case progresses, ensuring that decisions reflect the parent's recovery trajectory, the agency's efforts, and the child's need for safety and timely permanency. The following stages outline the core questions judges can use to guide hearings, from early shelter care through permanency and termination, helping the court assess service delivery, behavior change, parenting capacity, and the feasibility of reunification within the child's developmental timeframe.

Hearings that occur early in the case or shelter care

Judges should determine if appropriate SUD services were offered promptly at the assessed level of care and whether the least restrictive plan allows for safety and meaningful contact.

1. Questions to ask the agency, caseworker, or counsel

- What are the specific safety threats linked to substance use?
- Can I return this child home safely today?
- When was the SUD assessment completed? What does it recommend?
- What services have been offered, and when were referrals made? Is there a waiting list? Were medications for SUD (e.g., buprenorphine, methadone) offered if clinically appropriate?

- Are the services evidence based and consistent with the assessment?
- Is the family eligible for referral to a specialty court?
- What protective factors exist that could allow less restrictive contact or increased visitation? Are safe supports, sober caregivers, or other safeguards available?

2. Questions to ask the SUD treatment provider

- Please provide your initial assessment and recommendations.
- Is the level of care appropriate for this parent's needs?
- Should medications for SUD (e.g., buprenorphine, methadone) be considered for this parent?

3. Questions to ask the parent

- How is treatment going? How often do you attend?

- Tell me about your relationship with your treatment provider or counselor.
- How has substance use affected your parenting?
- What barriers are you facing in accessing services? What support do you need to be successful?

4. Questions for the child's attorney or guardian ad litem

- From your perspective, how has the parent's substance use affected the child's safety, daily functioning, and emotional well-being at this point?
- What does the child understand about what is happening right now (if age appropriate), and what concerns or needs has the child expressed?
- What immediate safety considerations or supports should be in place to protect the child while the case proceeds?

Middle of the case, adjudication, reviews

Judges should determine if the parent is demonstrating behavior change and engagement, not just attendance. In addition, determine if parental contact can be increased or restrictions reduced.

1. Questions to ask the agency, caseworker, or counsel

- Have there been any new safety concerns?
- What are the specific safety threats linked to substance use?
- Can I return this child home safely today? If not, what specific safety concerns prevent return?
- Has the parent been able to get into services? How long did the parent wait to access treatment after referral?
- What barriers exist to accessing services? What is the agency doing to address them?
- If services aren't available, what alternatives are being provided to the parent?
- What is the drug testing protocol (frequency, type of tests, observed/unobserved)? Has the parent missed any tests?
- Is supervised visitation tied to negative drug screens?
- What progress has the parent made in treatment?
- What behavior changes have you seen?
- What concrete behavior changes have you observed?
- What are the parent's strengths/protective factors?
- How is visitation going? Describe the parent-child interactions.

- Have parents missed visits? If so, what were the circumstances?
- Given the parent's current progress, how should we be increasing contact or reducing restrictions?

2. Questions to ask the SUD treatment provider

- Is the parent actively engaged or just showing up?
- What progress have you seen in the parent's insight, coping skills, and lifestyle changes?
- How do you assess the parent's current functioning?
- What is a realistic recovery timeline, given current progress?
- Is current progress sustainable?
- Is the parent receiving treatment for a co-occurring mental health disorder?
- If there was a return to use, do you view this as part of the recovery process or an indication of unsuccessful treatment in the past?

3. Questions to ask the parent

- What are you learning in treatment?
- What changes have you made in your daily life and routines?

- Where are you living? Is it stable? Is anyone there using substances?
- What are your triggers, and how are you managing them?
- What does your support system look like? Do you have a sponsor or peer support? How often do you connect with them?
- If there's been a return to use: What happened? What did you do about it? What have you changed since then? What did you learn?
- Tell me about your visits with your children. How are the visits going?

4. Questions for the child's attorney or guardian ad litem

- How is the child currently doing emotionally and developmentally, and what changes—positive or concerning—have you observed since the last hearing?
- Based on the child's needs, do current visitation or contact arrangements support stability and well-being, or should they be adjusted?
- From the child's perspective, is the parent's recovery progress translating into meaningful changes in safety, consistency, or parenting capacity?

Later in the case, permanency planning

Judges should determine if the recovery trajectory is stable and within the child's timeframe for permanency.

1. Questions to ask the agency, caseworker, or counsel

- Can I return this child home safely today? If not, what specific safety concerns prevent return?
- What would need to change for the child to safely return home?
- Is the parent following an individualized treatment plan?
- What does the treatment provider say about the quality of engagement (not just attendance) and progress?
- Looking at the entire case trajectory, is the parent improving, plateauing, or declining?
- Compare progress at 6 months vs. 12 months vs. now.
- What specific conditions still need to be treated?
- How much more time is needed, and what specifically needs to change?

2. Questions to ask the SUD treatment provider

- Given current progress and identified safety concerns, what is the least restrictive safety plan I can impose to maintain the connection between the parent and child?
- Can I return this child home safely today?
- What is the parent's prognosis?
- What behavior changes have you seen?
- Has the parent achieved a stable period of recovery?
- What recovery support and return-to-use prevention strategies do they use?
- Has the parent demonstrated the ability to maintain recovery while managing increased stress?
- Do you recommend continuing or extending services? What specific plan and timeline do you recommend?

3. Questions to ask the parent

- Looking back at when this case started compared to now, what's different about your recovery?
- Who will help you maintain stability and recovery once court involvement ends?
- What's your plan for managing stress and triggers when your child returns?

4. Questions for the child's attorney or guardian ad litem

- What is your assessment of the child's need for permanency at this stage, given their age, development, and time already spent in care?
- How does the parent's current recovery trajectory align, or not align, with the child's need for stability and permanency?
- In your view, what permanency outcome best serves the child's long-term safety, emotional health, and sense of belonging?

At a termination of parental rights (TPR) hearing

Judges should assess the totality of efforts, current parenting capacity, and the parent's likelihood of sustained recovery.

1. Questions to ask the agency, caseworker, or counsel

- Over the life of this case, what services were offered and when? Were they evidence based and appropriate?
- How did the agency respond to barriers?
- What services did the parent fail to engage in?
- Is the parent making measurable, sustained

treatment progress sufficient to ensure the child's safety and permanency?

- Do ongoing substance use issues continue to pose a direct risk of harm to the child despite available services?

2. Questions to ask the SUD treatment provider

- What is the parent's current capacity to provide safe care for their child?
- What is the likelihood of achieving sustained recovery if given more time?
- Has there been any sustained period of sobriety/recovery?

3. Questions to ask the parent

- What is your current status in treatment and recovery?
- Looking back, what would you have done differently?
- If given more time, what specifically would change?

4. Questions to ask the parent's counsel

- What is your client's position regarding the findings/orders?
- What does your client say about their progress and current situation?

- What barriers or challenges is your client facing that the court should know about?
- Does your client believe the services offered are appropriate and helpful?
- Do you believe the services offered are evidence based and appropriate for your client's needs?
- Has your client been able to access services in a timely manner?
- Are there services that should be offered that haven't been?
- What is the good-cause basis for an extension of the timeline? What specific progress has your client made despite continued challenges?

5. Questions for the child's attorney or guardian ad litem

- What is the child's perspective (if age appropriate) on parental SUD and recovery?
- How has the child been affected by the parent's substance use?
- What safety concerns do you identify for reunification?
- What is your position on the parent's recovery timeline and the child's developmental needs?
- Can the child safely wait for the parent's recovery?

Evaluating Reasonable/Active Efforts and Good Cause for Extension

Good-cause standards vary by state and tribal code. When assessing good cause, document specific findings about (1) the parent's genuine effort(s), (2) service adequacy, (3) the parent's likelihood of success with more time, and (4) the child's ability to wait.

Reasonable/Active Efforts Checklist for SUD

When a parent is affected by a substance use disorder, federal and state child welfare laws require that agencies make reasonable or, where applicable, active efforts to preserve the family, ensure child safety, and support the parent's ability to engage in treatment. At each hearing, judges play a critical role in determining whether the agency has taken meaningful, timely, and individualized steps to keep the child safely with the parent whenever possible.

This at-a-glance checklist is designed to help the court quickly assess whether those efforts reflect evidence-based practice, reduce unnecessary barriers to treatment, and uphold the parent-child relationship. Judges can use the checklist to guide inquiry on the record, reinforce accountability, and ensure that families affected by SUD receive the supports they need to work toward reunification.

- ☑ The parent has received prompt SUD assessment and appropriate, timely access to evidence-based treatment.
- ☑ Medications for SUD (e.g., buprenorphine, methadone) have been offered when clinically appropriate.
- ☑ Barriers have been accommodated, such as transportation, work schedules, and childcare.
- ☑ The parent has received co-occurring disorder assessment and treatment.
- ☑ The parent has received appropriate language services.
- ☑ The family has been given a voice in service planning.
- ☑ The least restrictive visitation conditions have been applied to support and encourage the parent-child relationship.

Factors Supporting an Extension

- The parent has demonstrated a genuine, sustained effort despite setbacks.
- There has been recent meaningful progress or a turning point in treatment.
- Delays in treatment have occurred due to a lack of available or appropriate services (i.e., agency failure, appropriate level of care not offered).
- Co-occurring disorders or complexity require more time.
- The treatment provider recommends an extension with a specific plan.
- A strong parent-child bond exists, and an extension will serve the child's best interests.
- There is a reasonable probability of reunification with additional time.

Factors Against an Extension

- A chronic pattern of continued use exists without sustained periods of sobriety when the parent had timely access to the assessed level of care.
- The parent has complied with services without meaningful behavior change.
- The parent has shown a pattern of not availing themselves of available treatment services or recovery supports.
- The parent has shown a continued lack of insight or minimization of problems.
- A treatment provider has expressed a clinical opinion of no reasonable likelihood of success, even with more time.
- An ongoing safety risk exists despite services.
- The child's developmental needs cannot wait.

Responding to Participant Behavior: Judicial Guidance

The following green and red flags offer judges quick, practical indicators of a parent's genuine progress or areas of concern when a substance use disorder is present. These cues can support judicial inquiry, help interpret treatment information, and guide balanced, child-centered decisions during review hearings.

Signs of Genuine Progress (Green Flags)

- **Honesty and accountability:** Self-reports struggles or returns to use.
- **Active treatment engagement:** Can articulate what they're learning, not just attendance.
- **Lifestyle changes:** Has new friends, stable housing, employment, new routines.
- **Insight:** Can articulate triggers and SUD impact on child and has a plan to prevent return to use.
- **Use of supports:** Has connected with a sponsor, recovery community, peers, mental health treatment.
- **Quality visits:** Is engaged, attuned to child's needs.
- **Provider support:** Treatment team sees meaningful progress.
- **Other protective factors:** Safety plan is being followed, safe caregivers are in place.
- **Compliance with safety planning:** Parent relies on safe caregivers when vulnerable.

Causes for Concern (Red Flags)

- **Minimization:** "It wasn't that bad" or blaming others.
- **Pattern of minimal compliance:** Doing just enough to avoid consequences.
- **Lack of insight:** Can't articulate how SUD affects parenting.
- **Dishonesty:** Has lied to providers, judge, or caseworkers.
- **No behavior change:** Is completing programs without making changes.
- **Escalating concerns:** Situation is worsening over time despite services.
- **Unsafe support system:** Is living with or relying on active users.
- **Provider shopping:** Is seeking less intensive treatment without clinical justification.
- **Missing drug tests:** Has a pattern of missed tests without valid explanations (i.e., distinguished from occasional logistical issues).

Assessing Return to Use: Context Matters

- **Parent's response and accountability:** Did they self-report or hide it? Did they immediately return to treatment?
- **Pattern over time:** Was there a random positive after months of abstinence, or was there ongoing use? Is it an isolated incident or a chronic pattern?
- **Protective factors in place:** Was the child with a safe caregiver when the parent used?
- **What changed?:** What is the parent doing differently now to prevent recurrence?
- **Treatment provider's opinion:** Do they view this return to use as part of the recovery process or as a sign of being unsuccessful in treatment?
- **Impact on children:** Was the child exposed, neglected, or in danger?

Remember: Return to use may be part of the recovery process, but a pattern of ongoing use without behavior change is concerning.

Balancing Safety and Recovery

- **Safety, not perfection:** Can this parent protect their child from harm while continuing recovery? (Many parents successfully parent while in recovery.)
- **Pattern vs. incident:** One setback after sustained progress is different from a chronic pattern without meaningful change.

- **Risk vs. uncertainty:** Distinguish actual safety threats from discomfort with uncertainty or a fear of "what if."
- **System accountability:** If the agency failed to offer timely, appropriate services, account for those delays when assessing whether the parent had adequate time.
- **Sufficient progress in sufficient time:** Progress matters, but is it enough progress, achieved quickly enough, for this child's age and needs?

Remember: Parents with an SUD deserve time to recover, but children also deserve permanency they can count on. Your job is to make an informed decision as to whether recovery and reunification can happen within this child's timeline.

Common Pitfalls to Avoid

- Treating all substance use the same without examining the context.
- Extending services indefinitely without clear benchmarks.
- Confusing attendance with engagement.
- Not addressing service gaps until a permanency hearing takes place.
- Making findings without specific factual support.
- Ignoring the child's timeline and developmental needs.

Judicial Scripts

These sample scripts offer judges concise, trauma-informed language to use during hearings involving parental substance use disorder. They are designed to support clear communication, reinforce accountability, acknowledge progress, and ensure that decisions remain grounded in the best interests of child safety and permanency. Judges may adapt these prompts to fit the case context, local practice, and the parent's stage of recovery.

Acknowledging progress while maintaining accountability:

I can see you're working hard and making progress. Recovery isn't easy. At the same time, we need to make sure [child] is safe and has permanency. Let's talk about what needs to happen between now and the next hearing.

When service delays occur:

I'm concerned that it took [X] weeks/months] for you to access treatment after referral. [Child] cannot wait for services that should have been available sooner. Agency, what is being done to address this gap?

Addressing return to use constructively:

I appreciate that you told the truth about your return to use. That shows growth. What I need to understand is what you're doing differently now so this doesn't happen again, especially when [child] is in your care.

When considering an extension:

I'm going to extend this timeline because I see genuine effort and recent progress. But [child] needs permanency. We cannot extend indefinitely. Let's be very clear about what needs to happen in the next [X] months.

When termination of parental rights may be necessary:

I know recovery is hard, and I respect that you have a disease. But my first responsibility is to [child]. After [X] months, we haven't seen the changes needed to safely return [child] home. [Child] cannot wait indefinitely.

Child Custody Proceedings

This section is designed to assist judges in family law cases involving custody, visitation, or parenting time when substance use or recovery concerns arise. It is not intended for cases in which child protective services are involved in limiting a parent's contact with the child.

Ex Parte/Temporary Restraining Order

Key considerations:

- Grant ex parte relief only when specific, credible facts allege imminent danger to the child arising from a parent's conduct that must be addressed before a hearing can be held.
- Evaluate the credibility, specificity, recency, and first-hand basis of allegations.
 - Is there a nexus between alleged substance use and imminent danger to the child (e.g., intoxication during parenting time or at pickup, driving impaired with the child, illegal drugs or paraphernalia accessible to the child, parent overdose, drug-related criminal activity)?
 - Does the source of the information lack credibility (e.g., hearsay, social media posts, retaliation, part of a pattern of abuse of court process)?
 - Absence of corroboration warrants caution.
 - Is the alleged conduct a concern that can wait for an evidentiary hearing (e.g., intoxication when not supervising the child, missed or positive drug tests)? Substance use or a positive drug test alone, without evidence of impaired parenting or risk to the child, is generally not sufficient to establish child danger.

- If credible, specific facts are sufficient to show that delay would expose the child to imminent serious harm, issue narrowly tailored, time-limited temporary relief to reduce risk (e.g., supervised exchanges, no overnights, visitation in public places only, family member present during visit, prohibition on driving with the child, video/phone visits), rather than a no-contact order.
- Set an expedited evidentiary hearing.

Initial Custody Hearing/Temporary Orders

Key considerations:

- Review pleadings for allegations that parental substance use may affect child safety.
- Observe the parent for indicators of possible parental substance use:
 - Courtroom behavior/demeanor: Erratic or disoriented behavior, signs of intoxication or withdrawal, repeated lateness or missed hearings.
 - Contextual information: Reports from the other parent, current job or housing instability, sudden behavioral changes, pattern of missed visits, estrangement from family.
 - Corroborating information: Records or input from schools/teachers, treatment providers, guardians ad litem, visitation supervisors, or neutral witnesses.

- Use neutral, respectful questions to gather information.
- Order screening and assessment when credible evidence suggests an SUD; encourage voluntary treatment and recovery supports.
- Use the least restrictive safety measures to protect the child.
- Consider appointing a guardian ad litem.
- Set a review hearing in 30 to 60 days to reevaluate child safety and parent progress.

Merits/Evidentiary Hearing (Final or Interim)

Key considerations:

- Determine what credible evidence establishes about parental substance use.
- Evaluate how SUD affects safety and parenting (e.g., driving under the influence with child, impaired supervision, individuals using dangerous drugs in the home), and avoid punitive or moralistic reasoning.
- Identify the parent's protective factors (e.g., sober support, treatment engagement, stable housing, employment, negative tests, parenting class).
- Ensure that all court orders impose the least restrictive conditions necessary to protect the child while meaningfully preserving the parent-child relationship.
- Set a review hearing to monitor progress if restrictions are imposed.

Review Hearing/Compliance Hearing

Key considerations:

- Review treatment participation and reports.
- Reinforce progress with judicial encouragement and recognition.
- Modify visitation or custody conditions based on progress.
 - Evaluate whether restrictions remain necessary.
- Support the parent's recovery and long-term stability. Encourage continued participation in recovery supports and parenting programs.

Contempt/Enforcement Hearings

Key considerations:

- Identify whether the violation materially affects the child's safety or impairs parenting.
- Require specific, credible evidence of impaired or unsafe parenting before restricting custody.
- Evaluate parenting behavior, recovery progress, and stability, not abstinence alone.
- Praise any parental progress, even as contact with the child is modified.
- Link responses to child safety, best-interest factors, and improving parental capacity; don't frame them as punishment for SUD symptoms.

Notes

Self-incrimination in family law cases

Questions about a parent's substance use can raise self-incrimination risks because information revealed may later be used in criminal cases, contempt proceedings, or child protection investigations. Limit questions to parenting and safety, and do not ask about criminal conduct. Avoid requiring admissions of illegal acts without counsel. Ensure that self-represented parents understand they may decline to answer questions that could expose them to criminal liability.

Cannabis use in family law cases

Cannabis use, whether medical or recreational, must be evaluated in context, not presumed to indicate unfitness. Judges should distinguish between legal use, misuse, and impairment and assess whether cannabis use has a demonstrable impact on parenting capacity or child safety. Tests showing cannabis use by themselves do not establish impairment or risk. Interpret results cautiously and in conjunction with other evidence of parenting behavior.

Drug test interpretation

Drug test results are reported as positive or negative based on preset cutoff levels. Quantitative levels (the amount detected) are not reliable indicators of frequency, severity, or impairment. Concentration values should not be used to infer new or continued use, progress, or parenting capacity.

Glossary

Stability: Consistency in housing, employment, relationships, and daily routines that support the child's sense of safety and predictability.

Protective factors: Conditions that reduce risk of harm and support recovery (e.g., sober support, stable housing, treatment engagement, positive co-parenting).

Least restrictive measures: Court actions that protect safety while preserving the parent-child relationship and promoting recovery.

Core Substance Use and Mental Health Terms

These terms describe the medical and behavioral aspects of substance use disorders and mental health conditions. Familiarity helps judges use accurate, nonstigmatizing language and better understand reports from treatment providers.

- **Substance use disorder (SUD):** A medical condition involving loss of control, risky use, tolerance, and withdrawal.
- **DSM-5-TR Criteria for diagnosis:** Substance use disorder is diagnosed based on 11 criteria from the DSM-5-TR, classified into:
 - **Categories:** The 11 criteria are grouped into impaired control (1-4), social impairment (5-7), risky use (8-9), and pharmacological dependence (10-11). (At least 2 criteria occurring within a 12-month period.)
 - **Severity:** Meeting two or three criteria indicates a mild disorder, four or five indicate a moderate disorder, and six or more indicate a severe disorder.
 - **Scope:** These criteria apply to various substance classes, including alcohol, opioids, cannabis, and stimulants.

- **Craving:** A strong urge to use substances, a diagnostic symptom of SUD.
- **Co-occurring disorders:** Having both a substance use disorder and a mental health disorder.
- **Withdrawal:** Physical and psychological symptoms after reducing or stopping use; may be life-threatening.

Recovery Stages and Outcomes

Recovery is a process that unfolds over time, with stages marked by the risk of return to use or stabilization. Judges who recognize these stages can respond appropriately.

- **Early remission (DSM-5-TR):** Defined as a period of at least 3 months but less than 12 months where none of the 11 criteria for a SUD have been met, following a previous full diagnosis. The exception is the criterion for craving, which may still be present.
- **Sustained remission (DSM-5-TR):** Defined as a period of 12 months or longer where, after previously meeting full criteria for a SUD, none of the 11 SUD criteria have been met, except for craving (or a strong desire to use the substance). This state indicates a stable recovery phase and is distinguished from "early remission" (3-12 months).

- **Abstinence vs. recovery:** Abstinence equals no use. Recovery equals a broader, ongoing process that includes stability, wellness, and goals. Abstinence focuses on the physical behavior of avoiding use and is a component of recovery. Recovery is the comprehensive process of healing a person physically and emotionally from the disease of addiction.
- **Recovery:** A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.
- **Recurrence or return to use:** The terms "return to use" and "recurrence" are clinical and less stigmatizing than "relapse," "lapse," "slip-up," or "fall."
- **Screening:** A brief tool to flag possible issues; determines need for assessment.
- **Assessment:** An in-depth evaluation for diagnosis and level of care.

Levels of Care (ASAM Criteria)

The American Society of Addiction Medicine (ASAM) defines levels of care to guide clinicians and care managers in making objective decisions about patient admission, continuing care, and movement along the continuum of care. Understanding these levels helps judges interpret treatment recommendations and impose conditions that are realistic, patient centered, and evidence based.

Level	Description	Example Services
RR	Recovery residence	Recovery support from peers and/or allied health staff; clinical services not provided; can be combined with 1.x or 2.x services to meet clinical needs.
1.0	Long-term remission monitoring	Recovery management checkups; rapid reengagement in care when needed.
1.5	Outpatient services	Less than 9 hours per week of clinical services.
1.7	Medically managed outpatient	Less than 9 hours per week of clinical services plus low-threshold medication initiation.
2.1	Intensive outpatient (IOP)	9 to 19 hours per week of clinical services.
2.5	High-intensity outpatient (H-IOP)	20+ hours per week; daytime treatment.
2.7	Medically managed intensive outpatient	9 to 19 hours per week of clinical services; treatment planning led by medical staff.
3.1	Clinically managed low-intensity residential	9 to 19 hours per week of clinical services; 24/7 residential supervision, support, and structure.
3.5	Clinically managed high-intensity residential	24/7 residential supervision, support, and structure; 20+ hours per week of clinical services.
3.7	Medically managed residential	24/7; treatment planning led by medical staff.
4	Medically managed inpatient	Hospital-based psychiatric; 24/7; treatment planning led by medical staff.

Treatment and Support Approaches

Courts interact with a range of treatment and support strategies, from medication and harm reduction to trauma-informed supervision. Knowing these approaches allows judges to make referrals and set conditions that align with best practices and promote stability.

- **Medication for substance use disorder (MSUD):** Covers medication for both alcohol use disorder and opioid use disorder and can include acamprosate, disulfiram, methadone, buprenorphine, and naltrexone. Note: Judges can encourage but not order MSUDs or any other treatment except as recommended by a licensed physician.
- **Health and safety strategies:** Narcan, MSUD, clean syringes, education.
- **Trauma-informed care/supervision:** Care and supervision that avoids retraumatization and promotes safety.
- **Psychosocial stability:** Consistent housing, income, support, and emotional regulation.
- **Service adjustments:** Modifications made in response to compliance (e.g., supervised visitations, review hearing frequency, changes in testing, peer support group, parenting class).

Stigmatizing Language

Stigmatizing language reinforces shame, discourages individuals from seeking help, and can influence judicial and public perceptions of people with substance use disorders. Using person-first, medically accurate, and recovery-oriented language helps promote dignity, supports engagement in treatment, and aligns with the understanding that addiction is a chronic, treatable medical condition.

- **Addict, junkie, drug abuser, alcoholic:** These labels define a person by their disorder rather than recognizing them as an individual with a medical condition. Use “person with a substance use disorder” instead.
- **Clean, dirty (referring to drug test results):** These terms moralize substance use, implying that a person is good or bad, rather than describing medical outcomes. Use “tested negative” or “tested positive” instead.
- **Substance abuse, drug habit:** “Abuse” and “habit” imply choice or moral failure. The preferred terms are “substance use disorder” or “substance use.”
- **Slip-up, relapse (used judgmentally):** These words can sound punitive. Use the alternative of “recurrence of use” or a neutral delivery of “return to use” to better recognize recovery as a process.
- **User:** Reduces a person to a behavior rather than recognizing the complexity of their condition.
- **Noncompliant, resistant:** These terms imply willful defiance; instead, use “not yet engaged in treatment” or “experiencing barriers to engagement.”
- **Failure, failed treatment:** Suggests moral weakness or hopelessness; use “treatment not yet effective” or “treatment not successful at this time.”



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