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Supreme Court of California
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Case No. S274943

IN THE SUPREME COURT OF THE STATE OF CALIFORNIA

IN THE MATTER OF N.R., Minor

LOS ANGELES DEPARTMENT OF CHILDREN AND FAMILY SERVICES,
Petitioner and Respondent,

v.

O.R.,
Objector and Appellant.

From an Unpublished Decision by the Court of Appeal
Second Appellate District, Division Five, Case No. B312001
On Appeal from the Los Angeles Superior Court,
Case Nos. 20CCJP06523, 20CCJP06523A
The Honorable Martha A. Matthews

APPLICATION FOR LEAVE TO FILE AMICI CURIAE BRIEF IN SUPPORT OF OBJECTOR AND APPELLANT; [PROPOSED] BRIEF OF AMICI CURIAE ASSOCIATION FOR MULTIDISCIPLINARY EDUCATION AND RESEARCH IN SUBSTANCE USE AND ADDICTION AND CALIFORNIA SOCIETY OF ADDICTION MEDICINE

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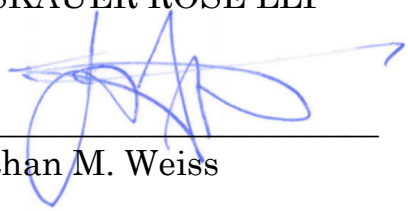
CERTIFICATE OF INTERESTED PARTIES

Pursuant to Rule 8.208(e) of the California Rules of Court, Amici Curiae certify that: (1) no entity or person has an ownership of 10 percent or more in the Association for Multidisciplinary Education and Research in Substance Use and Addiction, or in California Society of Addiction Medicine; and (2) they know of no other person or entity that has a financial or other interest in the outcome of this proceeding.

Dated: April 4, 2023

PROSKAUER ROSE LLP



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APPLICATION FOR LEAVE TO FILE AMICI CURIAE BRIEF IN SUPPORT OF OBJECTOR AND APPELLANT, O.R.

Pursuant to California Rules of Court, Rule 8.520(f), proposed amici curiae the Association for Multidisciplinary Education and Research in Substance Use and Addiction ("AMERSA") and the California Society of Addiction Medicine ("CSAM") (collectively "Amici"), respectfully request leave to file the accompanying [Proposed] Amici Curiae Brief in Support of Objector and Appellant, O.R.

AMERSA's mission is to improve health and well-being through interdisciplinary leadership in substance use education, research, clinical care, and policy. AMERSA operates with the goal of promoting and advancing multidisciplinary engagement, education, mentorship, and leadership among those who teach, study, advocate, and provide clinical care in the field of substance use and addiction. As part of its mission, AMERSA also aims to champion antiracism, equity, and inclusion for persons who are disproportionately affected by unhealthy substance use.

CSAM is the largest state chapter of the American Society of Addiction Medicine. The mission of CSAM is to advance the ethical and compassionate treatment of addiction through physician-led education of health professionals, patients, and the public. CSAM promotes practice, research, prevention, and implementation of evidence-based treatment and sound drug

policy. CSAM advocates for its patients, their families, and other support systems at all stages of care.

Both AMERSA and CSAM recognize the unfounded social stigma surrounding substance use and substance use disorders, and believe in unprejudiced, evidence-based drug policies. Amici also understand the significant risks of diagnosing "substance abuse" and substance use disorders using subjective, medically-unsupported criteria. Amici present this brief to advocate and provide medical context for the use of objective, scientifically-supported criteria to evaluate substance use disorders—particularly where such determinations could result in the loss of parental rights.

This application is timely under Rule 8.520(f)(2) of the California Rules of Court.

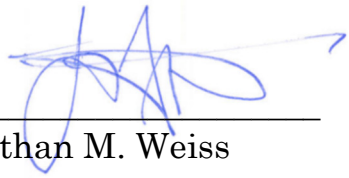
In accordance with California Rules of Court, Rule 8.520(f)(4), no party or counsel for any party in the pending appeal authored this brief in whole or in part and no party or counsel for any party in the pending appeal made a monetary contribution intended to fund the brief's preparation or submission. No person or entity other than counsel for the proposed Amici made a monetary contribution intended to fund the preparation or submission of this brief.

Pursuant to Rule 8.520(f) of the California Rules of Court, AMERSA and CSAM respectfully request that they be granted leave to file the accompanying amici curiae brief.

Dated: April 4, 2023

The Association for Multidisciplinary Education and Research in Substance Use and Addiction (AMERSA)

California Society of Addiction Medicine (CSAM)

By: 

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BRIEF OF AMICI CURIAE IN SUPPORT OF OBJECTOR AND APPELLANT, O.R.

INTRODUCTION

This case highlights the danger of allowing courts to diagnose parents with "substance abuse" problems based on their own subjective judgments rather than objective, scientific, evidence-based criteria. As this case illustrates, such subjective, standard-less judicial determinations can cause significant harm, including unnecessary judicial intervention into families' privacy and the wrongful separation of parents from their children. While the medical field strives to keep pace with scientific advancements in the field of substance use and substance use disorders ("SUDs"), progress is often hampered by myopic cultural attitudes. Unfounded assumptions and stigma—against substance use and individuals with SUDs—pose critical barriers to proper diagnosis and treatment and can cause significant harm, particularly when they are used as a basis to deprive parents of their fundamental rights and separate families.

Amici, the Association for Multidisciplinary Education and Research in Substance Use and Addiction ("AMERSA") and the California Society of Addiction Medicine ("CSAM"), are associations of individuals who have devoted their professional lives to understanding and treating SUDs. Amici submit this brief to emphasize the importance of applying consistent, evidence-based criteria, free from harmful assumptions and stigma, to

diagnose SUDs and determine whether a parent's substance use poses a risk of substantial harm to that parent's minor children.

This brief argues that the Court of Appeal and Juvenile Court (together the "Lower Courts") in this case erroneously conflated "substance *use*" with "substance *abuse*." The term "substance abuse"[1] is stigmatizing and outdated, and should be properly interpreted to refer to a substance use disorder, which can only be accurately diagnosed by a trained professional. Amici herein describe the significant distinctions between substance use and a substance use disorder, and explain that frequency, duration, and/or amount of substance use alone do not constitute diagnostic criteria for substance use disorders. Appellate courts have split over how to define "substance abuse," and Amici urge the Court to adopt the test developed in *Drake M.*, in which a finding of "substance abuse" can only be found by a trained professional or based on objective, scientific criteria.[2] Amici also explain that a urine drug test alone cannot diagnose a SUD—nor indicate whether or not the person was actively inebriated at the time of testing. Finally, Amici explain that scientific evidence does not support equating substance use with a "substantial risk of harm," and that parental substance use and substance use

[1] Though the brief at times uses the *legal* term "substance abuse," for clarity, the term is intentionally placed in quotation marks as it does not comport with current clinical terminology, which favors the term substance use disorder.

[2] *In re Drake M.*, 211 Cal. App. 4th 754, 766 (2012).

disorders do not automatically create a substantial risk of harm to children.

Welfare and Institutions Code § 300(b)(1) authorizes a juvenile court to exercise dependency jurisdiction over a child if "[t]he child has suffered, or there is substantial risk that the child will suffer, serious physical harm or illness, as a result of . . . the inability of the parent or guardian to provide regular care for the child due to the parent's or guardian's mental illness, developmental disability, or substance abuse." California Courts of Appeal have adopted different standards for what qualifies as "substance abuse" under this provision. In *Drake M.*, the Second District Court of Appeal, Division Three adopted objective, scientifically-based criteria from the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition ("DSM-IV-TR") for assessing whether a parent's substance use constitutes "substance abuse."[3] However, in *Christopher R.*, the Second District Court of Appeal, Division Seven held that Juvenile Courts were not required to use objective, evidence-based criteria, found the parent at issue "to be a current substance abuser" based on the Court's subjective beliefs concerning the parent's drug use, and exercised dependency

[3] *Drake M.*, 211 Cal. App. 4th at 766 (holding that a finding of substance abuse "must be based on evidence sufficient to (1) show that the parent or guardian at issue had been diagnosed as having a current substance abuse problem by a medical professional or (2) establish that the parent or guardian at issue has a current substance abuse problem as defined in the DSM . . .").

jurisdiction over her children.[4] This approach allows judges—who are not addiction medicine professionals—to create their own subjective standard, independent of generally accepted objective diagnostic criteria, for intervening into a family's privacy and removing a child from his parent's custody on the basis of substance use or "substance abuse."

In *Christopher R.*, the Court also adopted a rule that, for children of "tender years . . . 'the finding of substance abuse is prima facie evidence of the inability of a parent or guardian to provide regular care resulting in a substantial risk of physical harm.'"[5] This automatic presumption of harm is unsupported by scientific evidence and stigmatizes parents by equating substance use or a substance use disorder with a lack of parental fitness.[6]

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[4] *In re Christopher R.*, 225 Cal. App. 4th 1210, 1218-19 (2014) (explaining that "even if [Mother's] conduct fell outside one of the DSM-IV-TR categories," the Court of Appeal had "no doubt" that her substance use and other facts of her case "justified the juvenile court's exercise of dependency jurisdiction over her children").

[5] *Christopher R.*, 225 Cal. App. 4th at 1219 (citing *Drake M.*, 211 Cal. App. 4th at 756). *Drake M.* also adopted this rule. 211 Cal. App. 4th at 767. Accordingly, while Amici advocate for *Drake M.'s* objective test for "substance abuse," Amici do not support the *Drake M.* court's use of this automatic presumption of harm.

[6] *Public Policy Statement: Substance Use and Substance Use Disorder Among Pregnant and Postpartum People*, AM. SOC'Y OF ADDICTION MED. (Oct. 02, 2022), https://www.asam.org/advocacy/public-policy-statements/details/public-policy-statements/2022/10/12/substance-use-and-substance-use-disorder-among-pregnant-and-postpartum-people.

This is particularly dangerous in light of courts' frequent conflation of substance use and "substance abuse," as occurred in the instant case.

In the current case, the Second District Court of Appeal, Division Five (the "Court of Appeal") opinion relied on *Christopher R.* to affirm jurisdiction and a custody removal order based solely on the father's occasional drug use and other subjective, stigma-based assumptions ungrounded in science or any other objective criteria for diagnosing a SUD or a finding of substantial risk of harm to the child. Specifically, the Lower Courts made numerous assumptions and findings that are contrary to accepted practices in addiction medicine, including: 1) that the use of prohibited substances is tantamount to "substance abuse"; 2) that positive drug tests are evidence of active inebriation at the time of the test; and 3) that parental substance use necessarily poses a substantial risk of harm to a minor child.

Accordingly, Amici contend that the approach adopted by the Lower Courts encourages arbitrary judgments that reflect outdated, stereotypical notions of substance use to the extreme detriment of families, including undermining the recognized priority of parental reunification in dependency proceedings.[7] Amici therefore urge the Court to adopt the test for "substance abuse" developed in *Drake M.*, in which "substance abuse" is

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[7] *See Mark N. v. Superior Ct.*, 60 Cal. App. 4th 996, 1010 (1998) ("Family preservation is the first priority when dependency proceedings are commenced.") (citing *In re Precious J.,* 42 Cal. App. 4th 1463, 1472 (1996) and *In re Elizabeth R.,* 35 Cal. App. 4th 1774, 1787 (1995)).

defined and identified ideally by specialized addiction professionals, but at a minimum according to criteria set out in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (the "DSM-5-TR").[8] Amici agree that adopting such an objective, evidence-based test will prevent scientifically unfounded and biased assumptions from needlessly separating and harming families. Amici also encourage the Court to reject the rule, applied by the Lower Courts, that a finding of "substance abuse" is prima facie evidence of a substantial risk of physical harm to minor children. Rather, courts should engage in a fact-specific inquiry to determine whether a parent with a diagnosis of substance use disorder poses a substantial risk of harm to their children that would necessitate jurisdiction.

STATEMENT OF FACTS

On November 19, 2020, a referral was made to the Los Angeles Department of Children and Family Services (the "Department").[9] Police were about to execute a warrant on minor child N.R.'s mother's home. The social worker assigned to the matter subsequently asked that N.R. stay with Father for the length of the Department's investigation, to which Mother agreed.[10]

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[8] *Drake M.*, 211 Cal. App. 4th 754 (2012).

[9] Appellant's Opening Br. ("AOB") at 8, *In re N.R.*, No. B312001 (Ct. App. Sept. 22, 2021).

[10] *Id.* at 10.

Upon being informed of this new arrangement, Father headed to the home immediately, picked up N.R., and provided the social worker with his home address so that the home could be assessed.[11] When the Department asked Father about his drug use, he stated that he had not abused any substance and agreed to a drug test.[12] The Department noted that "the child was seen in the father's care and appeared to be comfortable. The child was seen clean, neat and on target with all developmental milestones."[13]

On November 23, 2020, the social worker received the urine test result for Father's drug test, which was positive for cocaine metabolites and negative for all other substances.[14] A week later—at which point Father had exclusive custody of N.R. for twelve days with no noted concerns—the social worker went to Father's home to discuss the results.[15] Father explained that he felt scared to tell the social worker that he had used cocaine the weekend before, while spending time with his friends celebrating his birthday.[16] He further explained that he did not habitually use cocaine and had not used since then—but understood the social worker's

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[11] *Id.*

[12] *Id.* at 11.

[13] *Id.*

[14] *Id.*

[15] *Id.*

[16] *Id.*

concerns for N.R. and took full responsibility for his actions.[17] While the social worker advised that the Department would request a removal order, Father committed to doing what the Department required of him.[18]

The social worker subsequently submitted an application for protective custody on December 7, 2020.[19] The order was approved, at which point N.R. had been in Father's care for almost twenty days with no concerns noted.[20]

The Juvenile Court found that the Department had shown that Father had a "substantial drug abuse history" and tested positive for what the Department characterized as "a fairly high amount of cocaine metabolites in November of 2020."[21] In response to the argument that Father never used cocaine while N.R. was in his custody, the Court noted that Father was responsible for taking care of N.R. at the time he received the positive test result.[22] The Juvenile Court found that the Department met its burden of showing that Father "is a recent abuser of cocaine" and that N.R. would be at a substantial risk of serious physical harm without the court's intervention.[23] The Juvenile Court then removed N.R. from

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[17] *Id.*

[18] *Id.*

[19] *Id.* at 18.

[20] *Id.* at 12.

[21] Op. at 8, *In re N.R.,* No. B312001 (Ct. App. Apr. 29, 2022).

[22] *Id.* at 9.

[23] *Id.*

Father's custody, placed N.R. with Mother, and ordered Father to submit to twelve drug tests and to participate in a parenting course.[24] Father was given limited visitation rights.[25]

In April 2022, the Court of Appeal affirmed jurisdiction and the custody removal order based on Father's admitted drug use.[26] The Court referred to the amount of metabolites in Father's urine to support a finding of "substance abuse."[27] Equating Father's substance use to "substance abuse," the Court found that there was a substantial risk of harm posed to the child, relying on *Christopher R.* for the proposition that a "finding of substance abuse is prima facie evidence of the inability of a parent or guardian to provide regular care resulting in a substantial risk of physical harm."[28] In support of its finding, the Court cited only Father's reaction to the "Department's discovery of his substance abuse" and his declination of additional services[29] as indications that "there was a risk of harm" to the child.[30]

Father then petitioned this Court for review. Father argues that the divergent standards for defining "substance abuse" issued

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[24] *Id.*

[25] *Id.*

[26] *Id.*

[27] *Id.* at 4.

[28] *Id.* at 12.

[29] The social worker had asked Father if he wanted to participate in the Child Family Team program. *Id.* at 6.

[30] *Id.* at 13.

by appellate courts generate serious and unfair disparity in the treatment of families—as well as unnecessary and harmful state intervention. Father also argues that the Court below erred in assuming that Father's cocaine use constituted "substance abuse" and in assuming that this automatically posed a substantial risk of serious harm to his child.

ARGUMENT

I. "SUBSTANCE ABUSE" UNDER SECTION 300 SHOULD BE INTERPRETED AS A SUBSTANCE USE DISORDER, A CLINICAL DIAGNOSIS THAT CAN ONLY BE MADE BY A TRAINED PROFESSIONAL.

In finding that substantial evidence supported the trial court's conclusion that Father's substance use constituted "substance abuse" under Section 300, the Court of Appeal erroneously conflated substance *use* with "substance *abuse*." The term "substance abuse" is largely no longer recognized in the medical community because it is pejorative and conveys stigma.[31] Instead, it is more appropriately recognized as a substance use disorder—a clinically diagnosed medical condition. Substance use, on the other hand, is merely a behavior in which many, if not most, people engage.

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[31] *Words Matter - Terms to Use and Avoid When Talking About Addiction*, NAT'L INST. ON DRUG ABUSE (Nov. 29, 2021), https://nida.nih.gov/nidamed-medical-health-professionals/health-professions-education/words-matter-terms-to-use-avoid-when-talking-about-addiction; Richard Saitz, et al., *Recommended Use of Terminology in Addiction Medicine*, 15 J. ADDICTION MED. 3 (2021).

A. Substance use, even in high amounts or with high frequency, is not equivalent to a substance use disorder.

Most people will use drugs at some point within their lifetime. According to the Substance Abuse and Mental Health Services Administration, over 78 percent of people aged twelve or older in the United States have used alcohol during their lifetime, almost 50 percent have used an "illicit drug" within their lifetime, and 14.6 percent have used cocaine.[32] In 2021, 62.3 percent reported using alcohol, 21.9 percent reported using "illicit drugs," and 1.7 percent reported using cocaine.[33] But despite the prevalence of drug use, most individuals do not develop SUDs. In fact, *most* drug use does not progress to a SUD.[34] Research shows that historically only about 15-20 percent of people who use cocaine develop a SUD.[35]

Individuals can use drugs, even in high quantities or at high frequencies, without necessarily developing a SUD.[36] The

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[32] *2021 NSDUH Detailed Tables: Illicit Drug Use/Misuse Tables* § 1, Tables 1.1–1.131, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN. (Jan. 4, 2023), https://www.samhsa.gov/data/report/2021-nsduh-detailed-tables (choose "Clickable Table of Contents"; then choose "PDF" next to "Detailed Table").

[33] *Id.*

[34] *Id.*

[35] Anne Katrin Schlag, *Percentages of problem drug use and their implications for policy making: A review of the literature*, 6 DRUG SCI., POL'Y & L. 1 (2020) at 5.

[36] *See 2021 NSDUH Detailed Tables: Substance Use Disorder and Treatment Tables,* § 5, Tables 5.1–5.44, SUBSTANCE ABUSE &

likelihood of developing a substance use disorder is influenced by a myriad of factors, including individual physiology, genetic makeup, adverse childhood experiences, and environmental circumstances.

1. The DSM-5-TR distinguishes between substance use and SUDs.

The DSM[37] is the "authoritative guide to the diagnosis of mental disorders for health care professionals around the world."[38] It is compiled by hundreds of experts, based on an extensive review of the latest literature. Addiction medicine is a rapidly evolving, highly specialized field, and the DSM, while not perfect, is the leading authority on diagnosing substance use disorders. The DSM publishes revisions over time to try to keep up with changes in the relevant scientific and medical literature and practice.

In 1987, when Section 300 was enacted, the version of the DSM in effect was the DSM-III. The DSM-III recognized

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MENTAL HEALTH SERVS. ADMIN. (Jan. 4, 2023), https://www.samhsa.gov/data/report/2021-nsduh-detailed-tables (choose "Clickable Table of Contents"; then choose "PDF" next to "Detailed Table").

[37] Amici will use the term "DSM" to refer to the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders in general, and not to any particular version of the manual. Amici will specify the edition by number (*i.e.*, DSM-III, DSM-IV-TR, or DSM-5-TR) when applicable.

[38] Am. Psychiatric Ass'n, *From Planning to Publication: Developing DSM-5* (2013), https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/DSM/APA_DSM-Development-of-DSM-5.pdf.

"substance abuse" as a diagnostic category.[39] The term "abuse," however, was found to be both stigmatizing and biologically inaccurate. Individuals dealing with addiction are not "abusing" a drug so much as purposely using it to experience a desired effect. More accurately, the problematic outcomes are caused by the specific consequences that flow from the use of the drug. In response to criticisms that the term "substance abuse" was stigmatizing and often resulted in diagnoses based entirely off the social or legal consequences of substance use, the authors of the DSM subsequently eliminated the term.[40] Instead, the current DSM-5-TR recognizes "an overarching new category of 'substance use disorders.'"[41] Studies have found that the new broader diagnosis is a "more accurate measurement of the underlying construct of stimulant addiction."[42] The criteria that were previously used in diagnosing "substance abuse," which focused on

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[39] "Substance abuse" was defined as: 1) a pattern of pathological use; 2) impairment in social or occupational functioning caused by the pattern of pathological use; and 3) duration of at least one month. *See* Am. Psychiatric Ass'n, *The Diagnostic And Statistical Manual Of Mental Disorders* 163 (3d ed. 1980) [hereinafter DSM-III].

[40] *See* Sean M. Robinson & Bryon Adinoff, *The Classification of Substance Use Disorders: Historical, Contextual, and Conceptual Considerations*, 6 BEHAV. SCIS. 18 (2016).

[41] Am. Psychiatric Ass'n, *The Diagnostic And Statistical Manual Of Mental Disorders* xxiv (5th ed. text rev. 2022) [hereinafter DSM-5-TR].

[42] Cristie Glasheen, et al., *Impact of the DSM-IV to DSM-5 Changes on the National Survey on Drug Use and Health* (2016), https://www.ncbi.nlm.nih.gov/books/NBK519702/.

the legal and social consequences of use (such as whether an individual had been arrested for substance use), had "little diagnostic information and a low rate of endorsement."[43]

Critically, the DSM-5-TR does not recognize "substance use" by itself as a clinically diagnosable condition. Instead, the DSM-5-TR identifies substance use disorders, which are "a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems."[44] It defines a "Stimulant Use Disorder" as:

> [a] pattern of amphetamine-type substance, cocaine, or other stimulant use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period:
>
> 1. The stimulant is often taken in larger amounts or over a longer period than was intended.
>
> 2. There is a persistent desire or unsuccessful efforts to cut down or control stimulant use.
>
> 3. A great deal of time is spent in activities necessary to obtain the stimulant, use the stimulant, or recover from its effects.
>
> 4. Craving, or a strong desire or urge to use the stimulant.
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> 5. Recurrent stimulant use resulting in a failure to fulfill major role obligations at work, school, or home.
>
> 6. Continued stimulant use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the stimulant.

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[43] *Id.*

[44] DSM-5-TR at 544.

> 7. Important social, occupational, or recreational activities are given up or reduced because of stimulant use.
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> 8. Recurrent stimulant use in situations in which it is physically hazardous.
>
> 9. Stimulant use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the stimulant.
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> 10. Tolerance, as defined by either of the following:
>
> > a. A need for markedly increased amounts of the stimulant to achieve intoxication or desired effect.
> >
> > b. A markedly diminished effect with continued use of the same amount of the stimulant.
>
> 11. Withdrawal, as manifested by either of the following:
>
> > a. The characteristic withdrawal syndrome for the stimulant . . .
> >
> > b. The stimulant (or a closely related substance) is taken to relieve or avoid withdrawal symptoms.[45]

The severity of a stimulant use disorder depends on how many of the eleven criteria are met.[46] The presence of two to three symptoms indicates a "mild" stimulant use disorder, four to five indicates a "moderate" stimulant use disorder, and six or more indicates a "severe" stimulant use disorder.[47]

The DSM-5-TR's eleven diagnostic criteria are based on a pathological pattern of behaviors related to use of the substance.

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[45] DSM-5-TR at 632-34.

[46] *Id.*

[47] *Id.*

The salient feature of a SUD is when an individual continues to use a substance that is harming them and is *unable* to stop. Substance use in and of itself is not equivalent to a medical condition or disorder of any kind.

2. The frequency, duration, or amount of substance use alone have never been diagnostic criteria in the DSM, because those metrics do not correlate with a lack of control.

Not only is substance use, on its own, not a diagnosable condition, but there is also no frequency, duration, or amount of use that would by itself equate to a substance use disorder. This is because substance use affects individuals differently depending on their environment, brain chemistry, and other unique characteristics. Diagnosing a substance use disorder also requires an aberrant pattern of behaviors, such as regularly taking more medication than prescribed. In that respect, quantity and frequency alone can be misleading. Tolerance, or taking larger amounts to get the same effect, is one of the criteria used to diagnose a SUD—but because tolerance is commonly observed in people who take certain medications, like opiates, clinicians do not use tolerance alone to diagnose a substance use disorder.

Notably, Criterion 1 ("[t]he stimulant is often taken in larger amounts or over a longer period than was intended") does consider the amount or duration of the substance use. But importantly, this factor directs clinicians to consider an individual's self-imposed limitations—not merely the gross amount or duration of substance use. In other words, when diagnosing a SUD, clinicians should

consider whether an individual's substance use exceeds the amount or duration that they intended to use, but the actual amount or duration itself is clinically irrelevant separate and apart from the individual's subjective intentions.

3. A positive drug test alone is not an indicator of a substance use disorder.

Because neither the fact of substance use nor the frequency, duration, or amount of substance use alone are factors that go into the diagnosis of a SUD, a single drug test cannot be used as a diagnostic tool. A drug test can only measure past use and thus is of little value in a clinical setting and of *no* value when assessing whether an individual has a SUD.[48] Even if, for example, a drug test indicates a high level of metabolites for cocaine,[49] it would not be relevant to any of the eleven diagnostic criteria discussed above, because substance use and amount of use are not diagnostic factors.[50]

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[48] *See* Nat'l Ctr. on Substance Abuse & Child Welfare, *Drug Testing For Parents Involved in Child Welfare: Three Key Practice Points* 3 (2021), https://ncsacw.acf.hhs.gov/files/drug-testing-brief-2-508.pdf ("The results of a single drug test cannot determine, or rule out, a SUD. While a series of tests can establish a pattern of use, they do not alone provide information on the severity of an individual's substance use, the effects on parenting capacity, or an individual's progress in recovery.").

[49] This also presupposes that the drug test is accurate, despite research showing that urine drug screens are prone to false positives. *See* D. Adam Algren & Michael R. Christian, *Buyer Beware: Pitfalls in Toxicology Laboratory Testing*, 112 MO. MED. 206 (2015).

[50] *See* DSM-5-TR at 632-33.

B. Substance use disorders are clinical conditions that should only be diagnosed by trained professionals—not courts.

Substance use disorder is a medical diagnosis—it is a "*mental disorder that affects a person's brain and behavior*, leading to a person's inability to control their use of substances such as legal or illegal drugs, alcohol, or medications."[51] Trained professionals can only diagnose SUDs after conducting a clinical interview and assessing the eleven DSM-5-TR criteria.

The DSM-5-TR is designed "first and foremost to be a useful guide to clinical practice . . . ."[52] It is a *diagnostic manual* for mental disorders.[53] Although it is intended to be used by experienced mental health professionals in a variety of roles—not just physicians—the criteria are "intended to facilitate an objective assessment of symptom presentations in a variety of *clinical*

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[51] *Substance Use and Co-Occurring Mental Disorders*, NAT'L INST. OF MENTAL HEALTH (Mar. 2023), https://www.nimh.nih.gov/health/topics/substance-use-and-mental-health#:~:text=A%20substance%20use%20disorder%20(SUD,most%20severe%20form%20of%20SUDs (emphasis added).

[52] DSM-5-TR at xxiii.

[53] Respondent makes a similar point in its Answer Brief but misconstrues its significance. *See* Answer Brief at 28. It is critical to note that, even if the DSM is intended to provide "clinical" guidelines, that is not a reason to thereby reject it in favor of allowing judges, who are not trained clinicians, to adopt a subjective, standard-less approach. Trained professionals should be the ones diagnosing SUDs—but the DSM provides an objective, science-based approach that is preferable to a standard-less approach, as explained *infra*.

settings—inpatient, outpatient, partial hospital, consultation-liaison, clinical, private practice, and primary care—as well in general community epidemiological studies of mental disorders."[54]

The DSM-5-TR provides a set of diagnostic criteria to consider when diagnosing a SUD. But actually using these criteria to make a diagnosis requires specialized training and education.[55] Mental health professionals, including psychiatrists, other physicians, psychologists, social workers, and other healthcare providers, are specially trained to conduct clinical interviews that, in combination with analyzing the DSM criteria, are critical to making a proper diagnosis.

While the DSM-5-TR attempts to lay out a set of objective criteria to consider, many of the criteria are still vague and require exploration and interpretation in a clinical setting. Criterion 1, for

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[54] DSM-5-TR at xxiii (emphasis added); *see also id.* ("Since a complete description of the underlying pathological processes is not possible for most mental disorders, it is important to emphasize that the current diagnostic criteria are the best available description of how mental disorders are expressed and *can be recognized by trained clinicians*.") (emphasis added).

[55] *See* Soteri Polydorou, et al., *Training Physicians to Treat Substance Use Disorders*, 10 CURRENT PSYCHIATRY REPORTS 399, 399 (2008); *see also* Edward V. Nunes et al., *Addiction Psychiatry and Addiction Medicine: The Evolution of Addiction Physician Specialists*, 29 AM. J. ADDICTION 390 (2020) (describing the addiction psychiatry and addiction medicine subspecialties that focus on providing care for patients with SUDs); Kevin Kunz & Timothy Wiegand, *Addiction Medicine: Current Status of Certification, Maintenance of Certification, Training, and Practice*, 12 J. MED. TOXICOLOGY 76, 77-78 (2016) (describing the specialized training completed by physicians in addiction medicine fellowship programs).

example, states that "[t]he stimulant is *often* taken in larger amounts or over a longer period than was intended."[56] But "often" is not defined. Nor does the DSM-5-TR provide any guidance as to how to determine whether an individual does in fact take stimulants in larger amounts or over longer periods than intended. Thus, to determine whether this first factor is present, a trained professional would need to conduct a clinical interview asking specific questions on these topics and basing their assessment on their clinical experience and expertise. They might ask, for example, "Have there been times when you would spend more time out drinking alcohol or using X substance than you had originally planned? Or spending more time using other substances? For which substances did that occur? When did you experience that?"[57]

Judges are not clinical or addiction medicine professionals and should not be diagnosing SUDs. Diagnosing a mental disorder is a *clinical* process that requires specifically trained professionals. Allowing judges to diagnose SUDs risks misdiagnosis at best—and at worst, it risks unjustifiably separating a child and parent, causing substantial harm to both. Thus, a finding of "substance

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[56] DSM-5-TR at 632.

[57] A few examples of semi-structured interview assessments are the Composite International Diagnostic Interview, Structured Clinical Interview for DSM, and Substance Use Disorder Diagnostic Interview. These all take at least thirty minutes to complete and require a nuanced back and forth with patients to accurately assess whether they meet certain criteria. *See* Nancy K. Young, et al., *Screening and Assessment for Family Engagement, Retention, and Recovery* D-1 (2016), https://ncsacw.acf.hhs.gov/files/SAFERR.pdf.

abuse" under Section 300 should be based on evidence sufficient to show that a trained clinician has diagnosed the parent with a SUD.

C. Should the Court decline to adopt this interpretation of Section 300, then a finding of "substance abuse" must *at least* rest on the objective criteria set forth in the DSM-5-TR.

If judges are to be put in the position of quasi-diagnosticians, then they must at a minimum look to the objective DSM-5-TR criteria when making a finding of "substance abuse" under Section 300. The alternative approach set forth by *Christopher R.* and adopted by the Lower Courts permits courts to ignore objective, medical criteria when evaluating whether a parent's substance use qualifies as "substance abuse." This approach disregards the extensive body of expertise and evidence around substance use disorders and can lead to stigma-driven decision-making and wholly subjective judgments, with harmful, dangerous results.

The DSM is the authoritative guide to the diagnosis of mental disorders for health care professionals. It is regularly updated to evolve with the latest scientific understandings. The DSM-5-TR, for example, "represents the contributions of more than 1,500 distinguished mental health and medical experts from around the world as part of an extensive and rigorous development process."[58]

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[58] Am. Psychiatric Ass'n, *From Planning to Publication: Developing DSM-5* (2013), https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/DSM/APA_DSM-Development-of-DSM-5.pdf.

Because the DSM is intended to be a practice manual for clinicians globally and in a wide variety of contexts, it is designed to create a "common language to communicate the essential characteristics of mental disorders presented" by patients.[59] The DSM-5-TR "criteria are concise and explicit and intended to facilitate an objective assessment of symptom presentations in a variety of clinical settings . . . ."[60] Using the DSM-5-TR's objective criteria, at a minimum, to determine whether there is "substance abuse" under Section 300 would ensure that courts do not take a wholly subjective "you know it when you see it" approach to invoke jurisdiction and decide whether minor children should be removed from their parents. It would also help to ensure uniformity across settings and prevent Section 300 from being enforced on an ad-hoc, subjective basis, which often disparately impacts communities of color.

Respondent argues that courts should not look to the DSM-5-TR criteria because 1) the DSM focuses on diagnosing and treating patients, "which inherently relies on cooperation and truthful information provided by the individual," and parents may not be truthful in the dependency context; and 2) the DSM does not assess risk to third parties—like children.[61] Neither point has merit. *First*, the DSM-5-TR criteria are not simply a checklist of questions that rely on honest answers. Rather, the DSM-5-TR

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[59] *See* DSM-5-TR at xxiii.

[60] *Id.*

[61] Answer Br. 48-49.

provides a set of diagnostic criteria that experts use to structure their own questions as part of a comprehensive evaluation that includes a detailed interview, as well as analysis of objective information such as employment history or interactions with the healthcare system. *Second*, many of the DSM-5-TR criteria *do* account for social and relational harms. For example:

- Criterion 5: recurrent stimulant use impairing the patient's ability to fulfill major obligations at work, school, or home.
- Criterion 6: continued stimulant use despite it causing persistent or recurrent social or interpersonal problems.
- Criterion 7: reduction or discontinuation of important social, occupational, or recreational activities because of substance use.

All of these criteria require an accounting of a patient's relationships—including with children—and are assessed as part of any guideline-based clinical evaluation for a SUD.

D. The record evidence shows only that Father *used* cocaine, but that is insufficient to diagnose a substance use disorder.

The Court of Appeal's decision illustrates the problem with allowing judges to diagnose substance use disorders based on subjective factors. Relying on *Christopher R*, the Court of Appeal found that Father's "rather longstanding cocaine habit, with intensive use on at least one known occasion, provides substantial

evidence to support the trial court's finding of substance abuse."[62] But this conflates substance *use* with "substance *abuse*," and does not, without more, rise to the level of a substance use disorder.[63]

A *mild* SUD requires meeting at least two of the eleven DSM-5-TR criteria over a twelve-month period. Yet here, there is no clear evidence that Father's reported use of cocaine meets even one of the criteria. As discussed above, frequency, duration, and amount of substance use alone are not criteria for diagnosing a SUD.

The salient feature of a SUD is the individual's inability to control their use of the substance despite it interfering in life activities, which is why the eleven DSM-5-TR criteria generally focus on recurrent or continued use despite adverse consequences.[64] Here, Father's losing custody of N.R. was the first "adverse consequence" he suffered from using cocaine. And, as

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[62] Op. at 11, *In re N.R.*, No. B312001 (Ct. App. Apr. 29, 2022).

[63] To be clear, AMERSA and CSAM do not take the position that Father could not have had a SUD. Rather, based on the evidence in the record, there is an insufficient basis to find a SUD and the Court of Appeal relied on erroneous criteria when making its finding. Moreover, any medical SUD diagnosis would also require a clinical interview and assessment.

[64] *See also Substance Use and Co-Occurring Mental Disorders*, NAT'L INST. OF MENTAL HEALTH (Mar. 2023), https://www.nimh.nih.gov/health/topics/substance-use-and-mental-health#:~:text=A%20substance%20use%20disorder%20(SUD,most%20severe%20form%20of%20SUDs ("A [SUD] is a mental disorder that affects a person's brain and behavior, leading to a person's inability to control their use of substances such as legal or illegal drugs, alcohol, or medications.").

discussed *infra*, there is no evidence that Father ever used cocaine while caring for his child.

In support of its decision, the Court of Appeals cited Father's failure to "disclose his substantial cocaine usage to the Department" and noted that Father "suggested his friends were funding his cocaine habit while he was less than fully employed . . . ."[65] Neither is relevant to diagnosing a SUD.

First, the failure to disclose past substance use is not part of the DSM-5-TR SUD criteria. Indeed, as even Respondent acknowledges,[66] many people who use substances initially deny such use, particularly in legal settings where there could be potentially life-altering adverse consequences.[67] The fact that someone admits to or denies having a substance use problem does not factor into clinicians' diagnostic determinations.

Second, the fact that Father was working part-time and did not purchase his own cocaine also does not indicate a SUD under the DSM-5-TR. While the Court of Appeal does not explicitly say so, the Court appears to imply that Father was only working at

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[65] Op. at 12, *In re N.R.*, No. B312001 (Ct. App. Apr. 29, 2022).

[66] *See* Answer Br. 48-49.

[67] Lindsay A. Pearce, et al., *Non-disclosure of Drug Use in Outpatient Health Care Settings: Findings from a Prospective Cohort Study in Vancouver, Canada*, 84 INT'L J. DRUG POL'Y (2020) at 3 ("People who use drugs may strategically choose not to disclose drug use or the full extent of their drug use to their health care provider over concerns of being denied care, as well as potential legal, child welfare, housing, and employment consequences associated with the criminalization of drug use[.]").

most twenty hours a week due to his "cocaine habit."[68] If Father was unable to maintain a full-time job due to recurring cocaine use, that could be considered evidence that he has a SUD.[69] But there is no evidence in the record to support such an argument. On the contrary, Father explained that he worked at a barber shop for four years but lost his job when the "COVID-19 pandemic [] shut down barber shops," and as a result he obtained a job working in a warehouse twenty hours a week.[70] Thus, there is no evidence that Father could not obtain a job due to his substance use—and it should not factor into the analysis of whether he has a SUD.

Respondent argues in its Answer Brief that Father's reported use of cocaine meets six of the DSM-5 criteria.[71] But this misguided analysis only further illustrates why the diagnosis of a SUD should be left to trained professionals:

- Criterion 1 (stimulant often taken in larger amounts or over a longer period than was intended): if anything, a stable pattern of volitional substance use cuts against a SUD.
- Criterion 3 (great deal of time is spent in activities necessary to obtain or use the stimulant, or recover

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[68] *See* Op. at 12, *In re N.R.*, No. B312001 (Ct. App. Apr. 29, 2022).

[69] *See* DSM-5-TR at 632 ("5. Recurrent stimulant use resulting in a failure to fulfill major role obligations at work, school, or home.").

[70] *See* AOB at 16, *In re N.R.,* No. B312001 (Ct. App. Sept. 22, 2021).

[71] *See* Answer Br. 50-51.

from its effects): a single four-day event does not qualify as a great deal of time.

- Criterion 4 (craving, or a strong desire or urge to use the stimulant): the mere use of a substance and the fact that someone's "eyes were always opened" is not evidence of a "craving" or "strong desire."
- Criterion 7 (important social, occupational, or recreational activities are given up or reduced because of stimulant use): the fact that Father intentionally used a substance at times that he *did not* have custody of his child cuts against this factor.
- Criterion 8 (recurrent stimulant use in situations in which it is physically hazardous): this factor is intended to cover *recurrent* use in dangerous situations such as driving a motor vehicle or use at work—not mixing cocaine and alcohol at a party.
- Criterion 10 (tolerance defined as needing markedly increased amounts of the stimulant to achieve intoxication or desired effect or a markedly diminished effect with continued use of the same amount of the stimulant): tolerance is a specific physiologic response to regular substance use over a *prolonged* period—four days is not nearly enough.

The Lower Courts' erroneous finding of "substance abuse" illustrates the dangerousness of *Christopher R*'s wholly subjective standard. Adoption of a "you know it when you see it" standard allows judges, who lack clinical experience, to unilaterally and

subjectively diagnose a parent with "substance abuse," and thus unnecessarily disrupt families, and in many cases, even remove a parent's minor children—in contravention of established medical criteria. This unjustifiable intervention harms both the parent and the child.

II. EQUATING SUBSTANCE USE WITH A SUBSTANTIAL RISK OF HARM IS UNSUPPORTED BY SCIENTIFIC EVIDENCE.

While the Court should adopt the test for "substance abuse" developed in *Drake M.*, it should reject the logic outlined in *Drake M.* and *Christopher R.* that a parent's substance use or substance use disorder automatically leads to a substantial risk of harm for children of tender years. Such findings are contrary to expert medical opinion and unsupported by scientific evidence. Here, the Lower Courts adopted this logic to determine that Father's cocaine usage and "abuse" put N.R. in substantial danger. However, the Court of Appeal failed to articulate any actual risk that N.R. faced while in Father's custody. The Lower Courts relied on a positive drug test and Father's self-reported prior substance use. But these have *no* bearing on whether Father was actively inebriated when he took custody of N.R. A positive drug test is not an indicator that a person is actively inebriated. And in fact, a Department social worker spoke with Father and inspected his home, and found no indication that Father was inebriated or that it was unsafe to leave N.R. with Father.[72]

[72] Op. at 4, *In re N.R.*, No. B312001 (Ct. App. Apr. 29, 2022).

Accordingly, both the Lower Courts' premise and evidence are scientifically unsound and contrary to medical and clinical professionals' understanding of risks to children caused by substance use and substance use disorders.

A. Parental substance use and SUDs in and of themselves do not necessarily cause a substantial risk of harm to minors.

Medical evidence does not support the assumption that parental drug use alone poses a substantial risk of harm to children. Studies and prevailing medical opinion show that a parent can use substances and still effectively parent.[73] Rather, when determining whether a parent's substance use poses a danger to his child, medical experts consider the consequences of the substance use and whether it impairs the parent's ability to properly care for the child.[74] For example, if a parent used substances and became incapacitated while caring for the child,

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[73] *See, e.g.*, Nancy J. Kepple, *Does parental substance use always engender risk for children? Comparing incidence rate ratios of abusive and neglectful behaviors across substance use behavior patterns*, 76 CHILD ABUSE & NEGLECT 44, 52 (2018).

[74] Am. Soc'y of Addiction Med. *Public Policy Statement on Substance Use, Misuse, and Use Disorders During and Following Pregnancy, with an Emphasis on Opioids* (2017), https://www.ncdhhs.gov/asam-substance-use-misuse-and-use-disorders-during-and/open; Dr. Ron Abrahams & Nancy Rosenbloom, *Effective Strategies for Courtroom Advocacy on Drug Use and Parenting*, AM. BAR ASS'N (Oct. 1, 2019), https://www.americanbar.org/groups/public_interest/child_law/resources/child_law_practiceonline/january---december-2019/effective-strategies-for-courtroom-advocacy-on-drug-use-and-pare/.

the substance use would likely pose a substantial risk of harm to the child due to parental neglect.[75] Similarly, evidence that a parent put himself and his child in physical danger to obtain a substance for the parent's use would show that the child faces a substantial risk of harm in the custody of the parent.[76] Clinicians with expertise in substance use and substance use disorders are best suited to make these assessments and determine whether a parent's substance use negatively affects the child's safety.

Likewise, a parent's diagnosis of substance use disorder does not automatically place a child at substantial risk, regardless of the child's age. For example, parents with a diagnosed SUD who are in treatment may be able to effectively parent with no risk to their children. Rather than applying an automatic presumption of harm, courts must engage in a fact- and case-specific inquiry to determine whether a parent's substance use disorder poses a substantial risk of harm to the child. Accordingly, even if the Court of Appeal correctly found that Father had a SUD (it did not), it would still need to articulate a present or future risk of harm to N.R. to warrant jurisdiction and removal.

B. The Lower Courts did not cite any evidence of parental impairment.

The Lower Courts did not cite any evidence that Father's substance use posed a substantial risk to N.R. or impaired his parental abilities in any way. Father represented—and all

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[75] Kepple, *Parental substance use*, *supra* note 73, at 45.

[76] *Id.*

evidence shows—that he was never inebriated while supervising N.R. Respondent does not directly dispute Father's representation.[77] There is no evidence in the record that shows Father used or was under the influence of cocaine while caring for N.R. Likewise, the Court of Appeal did not find that Father put himself or N.R. in *any* physical danger while using drugs or took any other actions that risked N.R.'s wellbeing.

Instead, the Court of Appeal held that in addition to Father's drug use, N.R. faced substantial risk because: 1) Father was upset that he got caught using cocaine; 2) Father missed drug tests; 3) Father declined to participate in the Child Family Team program; and 4) Father denied that his cocaine use was problematic.[78] This evidence is insufficient to establish that N.R. faced substantial risk in Father's custody. Father's reaction to the failed drug test does not show that Father's past substance use—or hypothetical future substance use—placed N.R. in danger. And while the Court of Appeal may find the missed drug test that Father did not make up and declination of the Child Family Team program concerning, they likewise are not evidence that N.R. faced a substantial risk of harm in Father's custody. Father submitted three negative drug tests and explained that he missed the other drug tests due to his work schedule. Respondent does not dispute either of these facts.

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[77] The Court of Appeal suggests that Father's positive drug test is evidence that he was inebriated when he took custody of N.R. As explained *infra*, this suggestion is contrary to scientific evidence and further demonstrates the dangers of the standards set by *Christopher R.*

[78] Op. at 10, 13, *In re N.R.*, No. B312001 (Ct. App. Apr. 29, 2022).

The Court of Appeal also cited the Department's jurisdiction and disposition report, which stated that Father's use of cocaine and alcohol at the same time creates a substance called cocaethylene.[79] Relying solely on the report rather than any scientific evidence or testimony, the Court of Appeal stated that cocaethylene "increases the addictiveness of each individual substance and the risk of violent behavior, paranoia, anxiety, depression, seizures, intense drug cravings, and sudden death."[80] Once again, the Court's reasoning is flawed and lacks scientific support. First, every individual produces different amounts of cocaethylene and it is "very difficult to predict cocaethylene concentrations in the blood, even when the exact amounts and timing of alcohol and cocaine use are known."[81] Here, exact amounts and timing are unknown. Moreover, cocaethylene (like any drug) affects each individual differently. No medical professional or addiction specialist analyzed Father to determine how cocaethylene affected him. Importantly, the Lower Courts did not find that Father himself displayed any of the symptoms it listed as associated with cocaethylene. Instead, the Lower Courts focused on the urine drug test for cocaine metabolytes (in the absence of symptoms). There is no evidence in the record indicating that the screening even tested for cocaethylene, which has numerous pharmacodynamic differences. Regardless, as

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[79] *Id.* at 7.

[80] *Id.*

[81] Joseph Pergolizzi, et al., *Cocaethylene: When Cocaine and Alcohol Are Taken Together*, 14 CUREUS (2022) at 5.

explained below, drug testing without a diagnosis of symptoms does not show that an individual is inebriated or otherwise affected by the substance.

Therefore, there is no evidence in the record showing either that cocaethylene was present, or that it affected Father's behavior in any way.

C. A positive drug urine test result does not indicate that a person is actively inebriated or "under the influence" of drugs.

Finally, the Court of Appeal improperly suggests that Father's positive drug test shows that he was actively inebriated when he took custody of N.R.[82] By suggesting that Father's positive drug test is evidence of his inebriation when he agreed to take custody of N.R, the Lower Courts display a fundamental misunderstanding of a drug test's function and capabilities.

1. Inebriation is a complex, multi-factor inquiry.

Inebriation cannot be deduced from a simple urine screen.[83] Urine drug screenings, or urinalyses, are deeply limited in their

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[82] *See* Op. at 10, *In re N.R.*, No. B312001 (Ct. App. Apr. 29, 2022) (explaining that the Juvenile Court found "[w]hile both Mother and Father claimed Father would not care for N.R. while using cocaine, it was undisputed Father was responsible for taking care of N.R. at the time of the November 2020 positive test").

[83] Janice L. Zimmerman, *Cocaine Intoxication*. 28(4) CRITICAL CARE CLINICS 517, 517-526 (2012).

diagnostic value and do not indicate active inebriation.[84] At best, they can detect a person's past substance use.[85] A person can receive a positive drug test result while being presently clear-headed and in control—and not under the influence of any substance. Thus, a parent can receive a positive drug test result while being entirely capable of safely and appropriately parenting the child (or children) presently in their care.

Inebriation or intoxication means that an individual is actively under the influence of a substance, such that their physical or mental abilities are currently being affected or impaired by the substance.[86] As an initial matter, evaluating inebriation requires a comprehensive examination that accounts for both setting and the person's tolerance. Tolerance, in turn, may range greatly from person to person, influenced by variables like genetics, body size, or history of substance use.[87] Inebriation may also present differently depending on the particular substance (or

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[84] *Id.*; *see also* Theresa Kurtz & Marcela C. Smid, *Challenges in Perinatal Drug Testing*, 140 OBSTETRICS & GYNECOLOGY 163, 163-166 (2022).

[85] Karen E. Moeller et al., *Clinical Interpretation of Urine Drug Tests: What Clinicians Need to Know About Urine Drug Screens*, 92 MAYO CLINIC PROC. 774, 744-786 (2017).

[86] Shannon Miller, *The ASAM Principles of Addiction Medicine* (6th ed. 2018).

[87] Francesca Ducci & David Goldman, *The Genetic Basis of Addictive Disorders*, 35 PSYCHIATRIC CLINICS 495, 495-519 (2012).

combination of substances) an individual has used and its mechanism of action.[88]

Cocaine, in particular, is a central nervous system stimulant.[89] It inhibits the presynaptic reuptake of certain neurotransmitters—namely, norepinephrine, dopamine, and serotonin. This inhibitory function can result in certain manifestations (or symptoms) of inebriation, including increased heart rate and blood pressure, euphoria, increased stamina, and a heightened sense of alertness.[90] On presentation, or upon medical examination, objective findings can also include mydriasis (dilated pupils), tachycardia (rapid heartbeat), hypertension (high blood pressure), diaphoresis (excessive sweating), and elevated body temperature.[91] Beyond these possible symptoms, cocaine is also generally very quickly absorbed and distributed, with effects of rapid onset and limited duration.[92] The onset of cocaine intoxication occurs within a few minutes depending on the route of administration (intranasal, intravenous, or by inhalation). Its duration is similarly short-term, ranging between 60-90 minutes

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[88] Zimmerman, *supra* note 83.

[89] Alan J. George, *Central Nervous System Stimulants*. 3 DRUGS IN SPORT 73, 73-111 (2003).

[90] Janice L. Zimmerman, *Cocaine Intoxication*. 28(4) CRITICAL CARE CLINICS 517, 517-526 (2012).

[91] *Id*.

[92] Rachel A. Goldstein, et al., *Cocaine: History, Social Implications, and Toxicity: a Review*, 26 SEMINARS IN DIAGNOSTIC PATHOLOGY 10, 10-17 (2009).

for intranasal use.[93] Regardless of the route of administration, however, symptoms of cocaine use only last a maximum of hours—not days.[94] Further, this list of anticipated symptoms, presentation, and duration of intoxication will vary depending on the person—and oftentimes by the route of administration. As such, there is no singular, generalizable test for whether someone is "under the influence" of cocaine. Tests for intoxication thus must be individualized, and active intoxication or inebriation cannot be evaluated based solely on a urinalysis screen.

2. Drug testing does not determine active inebriation.

Even assuming that the results are accurate,[95] urine drug screenings testing for cocaine cannot determine whether an individual is impaired from the drug at the time of the screening.[96] Urine drug screenings can detect both active drug compounds and inactive metabolites, which are compounds produced when the body processes or metabolizes a particular drug; they can remain

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[93] *Id*.

[94] *Id*.

[95] Michael A. Incze, *Reassessing the Role of Routine Urine Drug Screening in Opioid Use Disorder Treatment,* 181(10) JAMA INTERNAL MED. 1282, 1282-1283 (2021) (explaining how immunoassay-based tests are vulnerable to false positive results).

[96] Am. Coll. of Med. Toxicology, *Interpretation of urine analysis for cocaine metabolites*, 11 J. MED. TOXICOLOGY 153-154 (2015) ("[T]here is no scientifically or medically valid method to equate the mere presence (or quantitation) of cocaine or one if its metabolites in a particular person's urine with clinical impairment due to that drug.").

in the body for much longer than the active drug compounds actually causing impairment.[97] Cocaine—the active parent compound—has a very short half-life of 1-2 hours, while the metabolite benzoylecgonine has a much longer half-life of 7-9 hours.[98] Because of this, urine drug screens typically use immunoassays to test for the presence of biomarkers like benzoylecgonine, since they last longer in the body.[99]

While these residual inactive chemicals can indicate a person's past use of a substance, they do not provide any indication of whether that person is under the influence of the substance at the time of the test. Cocaine is deactivated through deesterification (hydrolysis) in the liver, making benzoylecgonine pharmacologically inactive.[100] While it has no intoxicating effect, benzoylecgonine can remain in the system and be detectable in the urine for several days after a single use of cocaine.[101] The presence

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[97] Randall C. Baselt, *Disposition of Toxic Drugs and Chemicals in Man* (7th ed. 2004).

[98] Michael Schrag, & Kelly Regal, *Pharmacokinetics and Toxicokinetics, in* A COMPREHENSIVE GUIDE TO TOXICOLOGY IN NONCLINICAL DRUG DEVELOPMENT 69, 69-106 (Ali S. Faqi, ed. 2013) (explaining that the half-life of a drug refers to the time required for the serum concentration to decrease by 50%).

[99] Mena Raouf, et al., *A Practical Guide to Urine Drug Monitoring*, 35 FED. PRACT. 38, 38-44 (2018).

[100] Eric T. Shimomura, et al., *Cocaine, Crack Cocaine, and Ethanol*. 2 CRITICAL ISSUES IN ALCOHOL AND DRUGS OF ABUSE TESTING 215, 215-224 (2019).

[101] Joyce Nickley, et al., *A Sensitive Assay for Urinary Cocaine Metabolite Benzoylecgonine Shows More Positive Results and*

of this inactive metabolite in the urine does not indicate current intoxication.

Multiple factors also implicate how quickly the body processes and eliminates metabolites from the bloodstream.[102] Individuals may use similar amounts of the same substance, yet display different test results, as a result of factors like genetics, body size, percentage of body fat, age, or sex. Some people may process metabolites more effectively, such that the test is limited even in its ability to predict how much and how recently an individual used a particular substance.

For these reasons, a positive urine drug test is not an indicator that a person is actively inebriated, or under the influence.[103] Urinalyses and urine toxicology reports are a tool of very limited value in the context of determining active inebriation. A parent can receive a positive urine drug test result while being entirely sober, in control, and wholly capable of safely parenting and caring for a child in their custody.

Longer Half-Lives than those Using Traditional Cut-Offs, 9 DRUG TESTING AND ANALYSIS 1214, 1214-1216 (2017).

[102] Ctr. for Substance Abuse Treatment, *Substance Abuse: Clinical Issues in Intensive Outpatient Treatment: Appendix B - Urine Collection and Testing Procedures and Alternative Methods for Monitoring Drug Use* (2006).

[103] Am. Soc'y of Addiction Med., *Public Policy Statement On Drug Testing as a Component of Addiction Treatment and Monitoring Programs and in other Clinical Settings*, (2010), https://www.asam.org/docs/default-source/public-policy-statements/1drug-testing---clinical-10-10.pdf.

In this case, Father's reported positive cocaine metabolite test and prior use had no bearing on whether he was actively inebriated when he took custody of N.R. Indeed, a Department social worker spoke with Father, inspected the home, and determined that there was no indication of inebriation or intoxication that would make it unsafe to leave N.R. in Father's care.[104] Accordingly, there was no inherent harm or risk in Father's taking custody of his child with a positive urinalysis result.

The Lower Courts' reliance on the positive drug test to show active inebriation further demonstrates the dangers of allowing judges to create their own standards for "substance abuse" and "substantial risk of harm." With no credible evidence of current inebriation—or evidence showing that Father's past substance use interfered with his ability to care for his child—the child was removed from his care. Penalizing Father (or any parent) in this way is dangerous, scientifically unsupported, and harmful to both parent and child.

CONCLUSION

Keeping families together is vital to their health, happiness, and well-being. Unnecessarily disrupting families and separating children from their parents, particularly on the basis of fundamental misunderstandings and stigmatized assumptions about the nature of substance use, is dangerous and harmful to both parents and children. The *Christopher R.* standard

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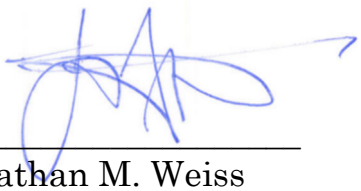
[104] *See* AOB at 10-11, *In re N.R.*, No. B312001 (Ct. App. Sept. 22, 2021).

improperly allows courts to set their own definition of "substance abuse" and "substantial risk of harm" based on arbitrary, unscientific factors—which are then relied upon to exercise jurisdiction and remove children from their parents. This case is a prime example of the dangers of allowing judges to diagnose substance use disorders and make child custody decisions based on subjective, standard-less determinations. The Court of Appeal upheld jurisdiction and the removal of N.R. from Father despite no actual evidence that Father: 1) had a substance use disorder; or 2) posed a substantial risk of harm to N.R. Therefore, Amici urge the Court to: 1) overturn the Court of Appeal decision; 2) uniformly adopt the *Drake M.* test for "substance abuse;" and 3) instruct lower courts that a finding of "substance abuse" is not prima facie evidence of a substantial risk of harm to minor children under Welfare and Institutions Code § 300(b)(1).

Dated: April 4, 2023

Respectfully submitted,

By: 

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Pursuant to Rule 8.520 (c) of the California Rules of Court and in reliance on the word count of the computer program used to prepare this Proposed Amici Curiae Brief, counsel certifies that the text of this brief (including footnotes) was produced using 13-point type and contains 9,355 words. This includes footnotes but excludes the tables required under Rule 8.204(a)(1), the cover information required under Rule 8.204(b)(10), the Certificate of Interested Entities or Persons required under Rule 8.208, the Application to File Amici Curiae Brief required under Rule 8.520(f)(1-3), this certificate, and the signature blocks.

Dated: April 4, 2023

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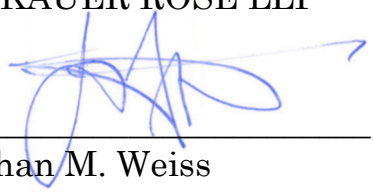

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PROOF OF SERVICE

IN THE SUPREME COURT OF CALIFORNIA

In re N.R.,

Supreme Court Case No.: S274943

Appellate Court Case No.: B312001

I, Sara Gothard, declare and state:

I am employed in the Parish of Orleans, State of Louisiana. I am over the age of 18 and not a party to the within action. My business address is 650 Poydras Street, Suite 1800, New Orleans, Louisiana 70130. I am employed in the office of a member of the bar of this court at whose direction the service was made.

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- **[PROPOSED] BRIEF OF AMICI CURIAE ASSOCIATION FOR MULTIDISCIPLINARY EDUCATION AND RESEARCH IN SUBSTANCE USE AND ADDICTION AND CALIFORNIA SOCIETY OF ADDICTION MEDICINE**

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I declare under penalty of perjury under the laws of the State of California and the United States of America that the above is true and correct.

Executed on April 4, 2023, at New Orleans, Louisiana

Sara Gothard

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Jorge E. Navarrete, Clerk and Executive Officer of the Court
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STATE OF CALIFORNIA
Supreme Court of California

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Supreme Court of California

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