

Strategies to Help CWS-Involved Parents Complete Substance Use Treatment and Protect their Children in Hawai'i

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Abstract

Each year in Hawai'i, an estimated 500–650 children (about half of confirmed cases of child abuse or neglect) are at high risk of entering foster care because of their parent's substance use disorder (SUD). Children in foster care because of parental SUD are less likely to be reunified with their parents. Experiences in foster care may cause long-term negative health consequences for the children. Early identification and engagement of parents in SUD treatment can improve outcomes for parents and children. The child welfare and SUD treatment systems in Hawai'i are not set up to work together to maximize the likelihood that parents will complete treatment and families will stay together. This article recommends evidence-based interventions including recovery coaches, peer partners, and Family Drug Courts (FDCs). Recovery coaches and peer partners support parents in early engagement and completion of SUD treatment. FDCs provide an interdisciplinary approach that successfully serves parents involved with Child Welfare Services (CWS) who have complex needs. Effectively implementing these interventions in Hawai'i requires an improved infrastructure to collect and analyze data about parents with SUD and their children, parents' SUD needs and status in treatment, and families' level of CWS involvement. Data about the availability and delivery of services for CWS-involved parents with SUD are also needed to understand service efficiency and effectiveness. These suggested interventions would help more parents in Hawai'i complete treatment and keep their children safely with them, thereby protecting children's current and long-term health.

Keywords

child abuse and neglect, substance use, child welfare, family reunification, substance use treatment

Abbreviations and Acronyms

ADAD = Hawai'i State Department of Health Alcohol and Drug Abuse Division
 AOD = Alcohol and Other Drugs
 CAN = Child Abuse and Neglect
 CARES = Coordinated Access Resource Entry System
 CWS = Child Welfare Services
 FDC = Family Drug Court
 SA-FTS = Salvation Army Family Treatment Services
 START = Sobriety Treatment and Recovery Teams
 SUD = Substance Use Disorder

Background & Introduction

Parental use of alcohol and other drugs (AOD) is one of the most common circumstances associated with child abuse and neglect (CAN).^{1,2} Many studies examine the percentage and number of CAN victims for whom parental substance use disorder (SUD) contributed to CAN, but the statistics are inconsistent.^{3,4} A 2007 meta-analysis of research studies revealed the wide range of estimated CAN cases with parental SUD; depending

on the sample used, the estimates ranged from 11% to 79%.³ In Hawai'i, AOD abuse are precipitating factors for about half of the confirmed CAN victims (**Table 1**). This paper highlights the key points focusing on CAN and the Child Welfare Services (CWS) system which stem from a chapter of the Hawai'i Department of Health Alcohol and Drug Abuse Division (ADAD) State Plan which examines the broader topic of the intersection of substance use and family violence. For more background and context around the overall State Plan project, readers are referred to the introductory article of this special supplement.

Every state has its own definition of CAN based on federal law. In general, CAN includes any of the following: physical, sexual, and emotional abuse of a person under the age of 18, and failing to meet the child's basic physical, medical, educational, and emotional needs.⁵ Hawai'i Revised Statute §350-1 lists circumstances that constitute CAN. Parental substance use or SUD does not by itself constitute CAN. Instead, CAN occurs when substance use negatively impacts parenting, such as when children's needs are not met because of the parent's use of substances. In addition, in several states exposing children to the possession or distribution of illegal drugs is a crime and constitutes child endangerment, but not in Hawai'i.⁶ In Hawai'i, manufacturing drugs in the presence of a child is a crime, and providing drugs to a child is CAN.^{7,8}

This article uses the term “mothers” depending on the context and research on which the discussion is based. The majority of parents in CWS⁹ or in Family Drug Courts due to CAN^{10,11} are

Table 1. Factors Precipitating Incidents for Confirmed Child Abuse and Neglect (CAN) Victims Among Hawai'i Children Birth to 18 Years, 2016 to 2020.^a

	2016	2017	2018	2019	2020
Confirmed Individual Victims	1351	1274	1267	1348	1198
Drug Abuse Involvement	40.8%	46.0%	42.0%	41.5%	42.1%
Alcohol Abuse Involvement	8.4%	8.9%	8.3%	7.5%	9.7%

^a Source: Annual statistical reports on child abuse and neglect (CAN) in Hawai'i (Hawai'i State Department of Human Services Audit, Quality Control and Research Office. Child Abuse and Neglect Reports. Published 2021. Accessed December 30, 2021. <https://humanservices.hawaii.gov/reports/child-abuse-and-neglect-reports/>

Notes:

- One incident could involve both drugs and alcohol and would be included in both categories.
- Precipitating factors are identified by child welfare service (CWS) and are not documented for every confirmed victim. Families who receive services through the CWS Differential Response System are not included in these numbers.

mothers. When only 1 parent is identified as a CAN perpetrator, mothers are twice as likely as fathers to be the identified perpetrator.^{12,13} Consequently, most research about parental SUD and involvement with CWS focuses on mothers. When research or data do not differentiate between “mother” or “father,” “parent” is used in the discussion. Following the terms used by systems that care for and support children who are harmed by CAN, the term “victim” is used when referring to children.

Parental SUD and CAN

As in most states, publicly available information about CAN due to parental SUD is limited and incomplete in Hawai‘i. As **Table 1** shows, CWS reports factors precipitating an incident of CAN, but only for confirmed CAN cases. Approximately 45% of families who receive a voluntary intervention after being reported to CWS do not have a confirmed incident of CAN.¹⁴ Data about whether parental SUD is a factor in these unconfirmed cases is not publicly available. Also, parental SUD may not always be successfully identified and recorded during an initial assessment phase by CWS. In addition to the lack of complete data about the incidence of CAN due to parental SUD, publicly available data does not include details such as sex of parents with SUD, child victim’s age, the level of CWS involvement, and treatment status and needs, all of which would help identify appropriate interventions.

Child Welfare Services Involvement

As **Table 1** shows, CWS identifies hundreds of Hawai‘i children at high risk of negative long-term harms due to parental SUD each year. Most of these children spend at least some time in foster care. Placement in foster care starts a legal clock that limits the amount of time parents have to regain custody. If a child has been in foster care for 15 of the most recent 22 months, Hawai‘i law requires CWS to terminate parental rights unless there is a compelling reason or failure to provide services for the parents.¹⁵ Thus, parents have about a year to complete SUD treatment, abstain from substance use, and demonstrate safe parenting. If parents continue to use substances and do not successfully complete treatment, they could lose their children permanently.¹⁶

Separation from parents places children at high risk for psychological distress, mental and physical health issues,^{17,18} and revictimization.^{16,19-21} Children who grow up in foster care have elevated risks of being homeless, abusing substances, experiencing long-term negative physical and mental health consequences, criminal justice involvement, early childbearing, and having their children placed into foster care.^{19,21-25} Furthermore, mothers who are involved with CWS and do not complete SUD treatment are likely to have subsequent births, and those infants are likely to be exposed to AOD in utero, increasing the number of CAN victims.²⁶ Therefore, when children can be kept safely with or reunified with parents who successfully complete SUD

treatment, that is usually better for their mental and physical well-being than out-of-home placement.^{9,21,25}

Despite the importance of parents’ completing SUD treatment for child well-being and family reunification, less than 25% of mothers in the child welfare system successfully complete treatment,²⁰ primarily because these mothers have more complex needs than other mothers with SUD.⁹ Mothers with SUD in the child welfare system are more likely to have co-occurring mental health disorders and trauma backgrounds, and struggle with poverty, unstable housing, employment, parenting, relationships, and life skills/household management.^{9,27} Unfortunately, in Hawai‘i and across the United States (US), sufficient services do not exist to support them and meet their complex needs.²⁷

Current System of Care in Hawai‘i

The Hawai‘i child welfare and SUD treatment systems are both state-administered systems utilizing federal funds and bound by federal and state laws. The systems are described in many publicly available documents, including state applications for and reports on federal funding to support these systems, such as the Department of Human Services Child Welfare Services Branch FFY 2021 Annual Progress and Services Report¹⁴ and the Department of Health Alcohol and Drug Abuse Division Substance Abuse Prevention and Treatment Block Grant applications. Descriptions of these Hawai‘i systems draw from official documents as well as from the expertise of professionals working with and in these systems.

Child Welfare System

The child welfare system includes CWS of the Hawai‘i Department of Human Services, private providers who are contracted to provide services for families who have been reported to CWS, the Family Court System, and a large network of other government and non-governmental agencies working with families served by CWS. Families usually become involved with CWS because of a CAN report made to the state CWS intake hotline. CWS has several options for protecting children and supporting families reported for CAN, regardless of whether CWS confirms CAN. To determine which option is best for a family, CWS assesses the safety of the children, risk factors such as parental SUD, and family strengths that might mitigate the risks. Each decision is individualized, so substance use in 1 family may lead to foster care placement while substance use in another family might lead to voluntary in-home services. Each family CWS serves has a Family Service Plan identifying the problems resulting in CWS involvement along with the steps that the parents must take to exit the system. If a family is receiving services that are tracked by CWS (with or without a confirmed CAN case), that family is considered “CWS-involved.” For parents with SUD, the CWS involvement usually lasts until the parent completes treatment, tests negative for drugs for several consecutive months, and completes other case plan requirements related to parenting.

SUD Treatment System

The SUD treatment system in Hawai'i includes the ADAD Coordinated Access Resource Entry System (CARES), private insurance providers, a statewide network of SUD treatment providers (many of whom are contracted through CARES), Drug Courts, and other government and non-governmental organizations that provide services to clients who participate in SUD treatment. The SUD treatment system has many entry points, although ADAD's goal is for CARES to be the main access point. CARES "provides a Continuum of Care [...] that includes] the following services for ADAD funded clients: screening, intake, assessment (as needed), care coordination, and referral and placement determination resulting in linkages to appropriate service modalities and resources."²⁸

Among the statewide network of independent SUD treatment providers with administrative, regulatory, and funding connections to the state Department of Health are 3 providers widely known to work with CWS-involved mothers: Women's Way on O'ahu (a program of Salvation Army Family Treatment Services (SA-FTS), Big Island Substance Abuse Council Moms and Babies Program, and Malama Family Recovery Center on Maui. These organizations provide a continuum of comprehensive gender-specific and trauma-informed services to women and their children, and many of the clients are involved with CWS. Through these programs, mothers can participate in residential SUD treatment and have their children live with them. Similar residential services for fathers do not exist in Hawai'i.

Interventions

This section discusses 2 evidence-based interventions that have been used or are being introduced in Hawai'i: recovery coaches/peer partners, and Family Drug Courts (FDCs). Both have been extensively examined for their effectiveness on these outcomes: increase in the likelihood of a parent's engagement in SUD treatment, faster and successful completion of SUD treatment, higher rates of reunification, and less time in out-of-home-placements for children.^{2,16,29-32} Findings from research studies conducted in other states indicate that these interventions are a good fit for the needs and infrastructure in the Hawai'i child welfare and SUD treatment systems. Furthermore, Hawai'i government and private agencies have demonstrated a readiness to implement them.

Recovery Coaches and Peer Partners

A recovery coach is a paid professional with training and/or certifications in SUD treatment and recovery who may work for CWS, FDC, or another organization, and who is individually assigned to a parent.³⁰ A peer partner is a parent who was involved with CWS because of SUD, completed treatment, abstains from substance use, and successfully parents their children.³⁰

Recovery coaches and peer partners play a substantial role in helping parents access services early. A randomized control study showed a statistically significant difference in the reunification rate when families were assigned to a recovery coach and also had early access to assessment and services (22% of families with a recovery coach and early access reunified within 3 years vs. 14% of counterparts with delayed access).² The group that only had early access and no recovery coach experienced no impact on the reunification rate.² Recovery coaches and peer partners also identify supports and services to meet parents' complex needs.³⁰ Needs, which contribute to lower reunification rates, include readiness to participate in treatment; availability of a spot in an appropriate treatment program; practical needs related to transportation, managing schedules, childcare, and money; managing the logistics of participating in treatment while completing other requirements in their CWS case plan; overcoming the stigma of addiction, being involved with CWS, and receiving SUD treatment; and learning safe and nurturing parenting without using substances.³⁰ Recovery coaches and peer partners are strong advocates for CWS-involved parents and give them hope that recovery is possible.³⁰

Recovery coaches and peer partners are active in many programs in the continental US. They usually exist within a structured SUD treatment program or as ancillary support. Their services may be reimbursable through Medicaid.³³ The peer partner program called Sobriety Treatment and Recovery Teams (START) is used in at least 7 states³⁴ and aims to keep children in the home and provide rapid access to both SUD and mental health services. The program aspires to assess and enroll parents in SUD treatment within 5 days from the first family meeting. START has been rated as a promising model in the Title IV-E Prevention Services Clearinghouse that rates interventions based on the evidence supporting the model.³⁰ A quasi-experimental study to evaluate outcomes found higher rates of sustained recovery from SUD for START participants than non-START counterparts (66% vs 36%), less use of foster care (50% less likely to be placed out-of-home compared to the children of non-START participating parents), faster achievement of sobriety (1.8 times faster than non-START participants), a significant reduction in recurrence of CAN, and cost savings to CWS (for every \$1 spent on START, \$2.22 is saved by Kentucky CWS).^{30,35}

Family Drug Courts

While the child welfare and SUD treatment systems collaborate at some levels to help clients reunify with their children, complete SUD treatment, and abstain from using substances, they operate independently of each other with separate goals and entryways. Their operations are guided or mandated by different federal laws and funding streams, and their focus, service delivery mechanisms, and desired outcomes are seemingly unrelated. Therefore, services, timelines, and treatment or family service plan goals are often not coordinated between the 2 systems, leaving clients to concurrently navigate 2 systems.

One place where the 2 systems deliberately coordinate is FDC. The FDC's objectives are "a safe and permanent placement for children through parent sobriety and the development of the skills and knowledge needed to become mature, responsible parents who can meet their children's developmental needs."¹² As previously mentioned, CWS-involved mothers with SUD have complex needs that cannot be addressed by 1 system or 1 approach.⁹ FDCs provide an interdisciplinary framework in which CWS and SUD treatment providers better collaborate to provide families holistic services and support.

Multiple reports summarize the many studies examining the effectiveness of FDC.^{16,31,32} For example, 1 study described the increase in success in parental SUD treatment by 25 to 35%, reduction in children's time in foster care, and increase in the likelihood of reunification by 15 to 40%.¹⁶ Effective FDCs emphasize coordination between CWS and SUD treatment services; utilize intensive case management and judicial monitoring through the FDC; require frequent drug testing; and hold weekly or biweekly court hearings about treatment progress where a FDC judge can give incentives for positive behavior and negative consequences for drug use or CAN.^{16,31,32}

Currently, hundreds of FDCs operate across the country, including at least 1 in Hawai'i. Despite the proven effectiveness of FDCs overall, no studies have been conducted on the Hawai'i FDCs. In fact, little information is available about the details of operations, outcomes, and assessment results of Hawai'i's FDC. Publicly available information includes only a brief description on the Judiciary website and a paragraph in the Hawai'i Fiscal Year 2020/2021 Substance Abuse Prevention and Treatment Block Grant Plan submitted by ADAD.³⁶ According to the paragraph, the State Judiciary Family Court of the First Circuit on O'ahu operates a FDC that "provides services for pregnant women and women with dependent children whose children are placed at risk by their parents' involvement in substance abuse and who have open cases with CWS. The FDC provides intensive family case management services through substance abuse treatment matching and coordination of the entire system of care between treatment and the Family Court."³⁶ The Hawai'i State Judiciary Annual Reports for 2019 and 2020 do not mention FDCs; however, they both include a section on regular drug courts.

It is difficult to measure effectiveness of the Hawai'i FDC in the absence of publicly available detailed information. However, in 2021, the Hawai'i Department of Health commissioned a research project in the FDC. The project found that CWS was referring very few cases to FDC because of staff shortages and high turnover at CWS.³⁷ High turnover results in a limited number of CWS workers who understand the benefits of FDC and how to refer families there.³⁷

Observations & Recommendations

The following observations and recommendations were generated from the authors' viewpoints informed by Hawai'i research and pilot programs as well as conversations with system stakeholders.

Use Recovery Coaches and Peer Partners

Hawai'i CWS does not currently use recovery coaches or peer partners; however, these interventions should be explored. Some efforts exist to develop these interventions in Hawai'i. For example, in mid-2020, the Hawai'i Maternal Infant Health Collaborative convened partners to develop a peer partner concept and apply for funding for a pilot program to support parents with SUD who are pregnant or involved with CWS. The Hawai'i Department of Health funded the research by the Association for Infant Mental Health Hawai'i that led to the proposal. The peer partner pilot was funded and began in spring 2022 at the PATH Clinic, a women's health services clinic located on the SA-FTS campus.

Many SUD treatment programs in Hawai'i use recovery coaches or peer partners, but they do not necessarily follow a specific evidence-based model. Programs designed for mothers, like Women's Way, Moms and Babies, and Malama Family Recovery Center, should consider exploring using an evidence-based model for recovery coaches and peer partners for mothers involved with CWS. Any such interventions should be implemented in consultation with CWS.

Expand Family Drug Courts

The demonstrated success of FDCs in increasing parents' completion of treatment and reducing children's time in foster care elsewhere indicates that improving utilization of the O'ahu FDC and creating effective FDCs on the other islands should help to mitigate the heavy burden on the Hawai'i child welfare system because of SUD. Achieving consistently successful FDC outcomes in Hawai'i would require some changes. For example, the systems would need to develop a streamlined referral pathway from CWS to FDC and to SUD treatment, and an effective way to evaluate the impact of FDC on CWS-involved parents with SUD. Additionally, every island needs at least 1 FDC to ensure access to services. On Maui, the Second Circuit had a FDC from 2005 until spring 2021, when funding was eliminated and the program was discontinued.³⁸

Collect Information to Provide Efficient Interventions and Evaluation

Recovery coaches, peer partners, and FDCs are well-researched interventions that are likely to improve outcomes for hundreds of children in Hawai'i. However, implementing them in the most beneficial manner requires additional information. Currently,

minimal disaggregated data exist about parents with SUD and their children, including parents' needs regarding support, level, and type of treatment. Data about the availability, capacity, and quality of services for CWS-involved families because of SUD are not widely available either. Collecting such information would inform decision-making about interventions most likely to improve outcomes for CWS-involved parents with SUD, such as where the interventions are most needed and how many parents need the services. This information would also provide baseline data for evaluating interventions. Additionally, it would be helpful to learn what interventions have been implemented and/or discontinued, such as the closure of the Maui Family Drug Court. **Table 2** lists information that would be particularly helpful to collect.

Examining the current referral pathway from CWS to SUD treatment is especially important. An efficient referral process helps parents with SUD to quickly engage in and complete treatment, which keeps their children out of foster care or reduces their time in foster care. Currently, there are no publicly available data that provide insight into the referral pathway, such as how long it takes for Hawai'i parents to engage in treatment and what alternative services are provided if there is a delay in accessing treatment.

Conclusion

Each year, CWS intervenes in the lives of hundreds of Hawai'i children because of their parents' SUD. Children of parents with SUD face a lifetime of risk factors. While CWS involvement can increase child safety and start families on a path to SUD recovery and safe and nurturing parenting, the current system can also cause additional trauma to parents and children. To minimize the adverse effects of SUD and keep parents and

children together safely, the systems serving these families could better collaborate and utilize evidence-based interventions that will help parents quickly access and complete SUD treatment and successfully exit the child welfare system. Introducing recovery coaches and peer partners in more programs and expanding FDCs on all islands in Hawai'i are 2 suggested measures. Implementing strategies to increase the number of CWS-involved parents who remain in recovery would protect multiple generations of children from negative effects on their well-being.

Conflict of Interest

None of the authors identify a conflict of interest.

Notice of Duplicate Publication

This article is based on the draft version of a chapter from the Hawai'i State Department of Health Alcohol and Drug Abuse Division (ADAD) State Plan, and all or a majority of the contents within will be subsequently also reproduced in the corresponding chapter of the final version of the ADAD State Plan (<https://health.hawaii.gov/substance-abuse/state-plan/>). While the ADAD State Plan may later be modified as a living document following its release, the material and content found in this article represents a snapshot of the highlights of the ADAD State Plan at the time of the article's publication.

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Information Needed	Purpose
Number of mothers, fathers, other caregivers with SUD (each category listed separately)	Understand the demand for SUD treatment services
Disaggregated data about children whose parents have SUD including children's ages, which caregiver has SUD, and children's ages at foster care entries and exits	Determine needs related to parents keeping children with them during residential treatment and understanding which ages are most impacted by SUD
Types of SUD treatment CWS-involved parents were referred to and/or participated in (inpatient, outpatient, etc.)	Understand the demand for and utilization of SUD treatment services
Referral pathway from CWS identifying SUD to parents participating in treatment, including timeframes, types of services parents are referred to, frequency of drug screens, other supports provided	Identify what is and is not working in current process; identify where recovery coaches or peer partners could fit into the process; better understand demand for SUD treatment and time frames for completion; better understand other supports offered to families; identify strengths, needs and gaps
Number of CWS-involved families who participate in Family Drug Court, the referral pathway, and the short- and long-term outcomes for those families	Understand how families currently access Family Drug Court services and where barriers exist; understand the effectiveness of Family Drug Court to improve the process and outcomes; identify gaps such as aftercare supports
Available slots, locations, and eligibility requirements for comprehensive, holistic treatment that addresses SUD and parenting	Understand the supply of specialized SUD treatment services and educate courts and CWS about appropriate services
Number of CWS-involved parents who complete treatment; number of parents who maintain sobriety over time; outcomes of their CWS cases	Understand treatment retention and completion rates; understand the effectiveness of treatment; look for connections between treatment and positive CWS case outcomes; identify gaps such as housing, financial support and aftercare supports

CWS = child welfare services; SUD = substance use disorder

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