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Recovery under two clocks: Parents, treatment, and child-welfare timelines

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ABSTRACT

Parents receiving substance-use treatment while involved with child welfare must respond to two different timelines: recovery is nonlinear and relational, while legal and permanency processes require documented progress on fixed schedules. This essay examines that conflict through the Family First Prevention Services Act and argues for coordinated plans, practical access supports, transparent documentation, and safety responses that prepare for recurrence of use without treating it as a moral verdict.

Keywords: substance use recovery, child welfare, family preservation, FFPSA, social work

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Origin in my MSW journey

> *This essay was adapted from a 2026 MSW child-welfare policy paper and reflections from work in a residential recovery setting. All client names, quotations, histories, and case details were excluded. The article discusses recurring practice conditions, not a disguised individual case.*

In residential recovery work, I learned that a parent can be doing difficult, meaningful work and still appear to be standing still on paper. Early recovery may involve withdrawal, disrupted sleep, grief, shame, health appointments, benefits problems, new routines, and the gradual repair of trust. Child-welfare and court processes, meanwhile, need dates, attendance, screens, visits, releases, reports, and evidence of progress.

Both systems have reasons for moving as they do. Children cannot wait indefinitely for safety and permanency. Recovery cannot be compressed into a checklist simply because a hearing is approaching. The practice problem begins when each system treats its own clock as the only legitimate one.

> **A parent may experience treatment as transformation while the system experiences it as a series of verifiable events.**

The overlap is common and consequential

National Center on Substance Abuse and Child Welfare data show that parental alcohol or other drug use was recorded as a condition associated with removal for 39.1% of children in out-of-home care in 2021, up from 18.5% in 2000. The center cautions that identification and data-entry practices differ, so the figure should not be read as a precise measure of causation. It does show how often substance use appears in the administrative story of removal.

The wording matters: "condition associated with removal" does not mean substance use was the only cause. Families may also be navigating unsafe housing, intimate-partner violence, poverty, untreated mental-health needs, transportation barriers, or limited child care. An effective plan must identify the actual safety pathway rather than assume one diagnosis explains the family.

What Family First changed, and what it did not

The Family First Prevention Services Act of 2018 opened a path for Title IV-E funding for time-limited, evidence-based mental-health, substance-use, and in-home parenting services intended to help children remain safely with their families. The law also established evidence requirements implemented through the Title IV-E Prevention Services Clearinghouse. This was a significant policy shift toward prevention rather than waiting until foster-care placement.

Funding authority, however, is not access. A service can be approved and still have a waitlist. A parent can be referred and still lack transportation, a phone, an evening appointment, language access, or child care. A residential program can document attendance while the parent's visit schedule remains incompatible with treatment programming. Policy creates a door; implementation determines whether a family can reach and open it.

Compliance language can hide logistics

"Missed screen," "late visit," and "failed to complete referral" sound like individual actions. Sometimes they are. Sometimes the bus did not arrive, the lab closed, the worker changed, the release expired, or the parent had to choose between a required group and a child-welfare appointment. Good documentation should not erase responsibility, but it should locate the barrier accurately.

A coordinated plan can reduce conflicting demands. At minimum, it should identify one lead contact, the safety goals, each service's purpose, the evidence each system needs, releases and their limits, transportation and child-care arrangements, and what happens when schedules collide. The parent should be able to see the same plan that professionals use to evaluate them.

Recurrence of use requires a safety response

Substance-use disorders can involve recurrence of use. That fact cannot predetermine a child-safety decision: the circumstances, caregiving impact, available protective adults, and immediate risk still require assessment. It does mean systems should plan before a crisis rather than rely only on punishment afterward.

A family-centered safety plan may identify early warning signs, safe caregiving alternatives, who can be called without delay, medication and overdose-response considerations, transportation, re-entry to treatment, and how parent-child contact will be reassessed. The plan must be specific enough to protect the child and realistic enough that the parent will use it. Automatic moral language such as "threw everything away" or "doesn't care" adds heat without adding assessment.

Residential programs need role clarity

Treatment staff can become translators between the parent and the child-welfare system. They confirm attendance, explain program structure, document goals, and help parents prepare for meetings. That contribution is valuable, but it creates pressure to become an arm of surveillance. Programs should state what they will document, what requires authorization, what remains clinically private, and what must be disclosed for safety or law.

Useful reports are objective and limited to purpose: dates of participation, the domains being addressed, observed engagement described behaviorally, barriers reported, agreed next steps, and concerns that fall within the writer's role. A treatment provider should not make legal conclusions outside their competence, and a court-facing letter should not become a complete clinical history by default.

Equity must be measured at the access point

Prevention funding can reproduce inequity if the best-supported programs are not available in the neighborhoods, languages, schedules, or formats families can use. Systems should examine referral-to-start time, completion, family experience, and outcomes by race, ethnicity, language, disability, geography, and placement status. They should also review who is deemed ineligible and why.

Evidence standards answer whether a program has credible support. Equity review asks who receives that program under workable conditions. Family preservation needs both questions.

A practice standard for the two clocks

1. **Translate requirements into one shared plan.** Reduce duplication and make deadlines visible.

2. **Document progress and barriers.** Record learning, participation, protective actions, waitlists, transportation, and scheduling conflicts.

3. **Coordinate with consent.** Share the minimum information necessary for the agreed purpose.

4. **Plan for risk before crisis.** Specify safe caregiving and rapid treatment responses if use recurs.

5. **Keep the child's experience central.** Family-centered does not mean adult-only; visits, transitions, and uncertainty affect children.

6. **Audit access and outcomes.** Prevention should be evaluated by who can actually receive it and what happens next.

What I carried from the field into policy

My MSW policy work gave names and funding structures to a tension I had already felt in practice. Recovery asks for patience, honesty, repetition, and connection. Child welfare asks for safety, proof, and decisions within time. The answer is not to stop either clock. It is to build a bridge between them so that a parent's work becomes visible, barriers are not mislabeled, and safety planning remains concrete.

Family preservation is credible only when it protects children and makes recovery realistically possible. That requires more than an approved service. It requires coordination designed around the lives of the people expected to complete it.

References and further reading

- U.S. Administration for Children and Families. Title IV-E Prevention Program.
- Title IV-E Prevention Services Clearinghouse.
- National Center on Substance Abuse and Child Welfare. Prevalence of parental alcohol or drug abuse as a condition associated with removal.
- National Institute on Drug Abuse. Treatment and recovery.

Publication note

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