
PRIORITIES FOR ADVANCING RESEARCH TO IMPROVE CARE FOR PARENTS WITH SUBSTANCE USE DISORDERS

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Glossary

Child welfare system: “A group of services designed to promote the well-being of children by ensuring safety, achieving permanency, and strengthening families” (Child Welfare Information Gateway, 2020, p. 2).

Evidence-based treatments or services: Treatments or services that have been scientifically evaluated and determined to be effective and appropriate based on the best available evidence.

Family separation: The involuntary restriction of parents’ access to their child.

Kinship care: “Kinship care is when children and youth live with relatives, such as aunts, uncles, grandparents, siblings, extended family, or fictive kin (those known to the family)” (Child Welfare Information Gateway, n.d.).

Parent: Includes biological, adoptive, foster, and step-parents, as well as guardians and custodians of minors. A parent is anyone who cares for a child's safety and welfare. This also includes bereaved parents or parents who have experienced custody loss who may no longer have parenting responsibilities for their child.

Reunification: The bringing together of a child and their parent(s) after a period of separation, regardless of whether that separation was voluntary or involuntary.

Services: Medical, psychological, legal, social, or financial supports that intend to promote the well-being of parents who use substances.

Substance use: The use or misuse of any psychoactive drug (both licit and illicit).

Substance use disorder (SUD): A chronic, treatable, condition that includes uncontrolled use of a substance despite harmful consequences.

Trauma: “An emotional response to a terrible event like an accident, crime, natural disaster, physical or emotional abuse, neglect, experiencing or witnessing violence, death of a loved one, war, and more” (American Psychological Association, n.d.).

Statement of Purpose

The goal of these research priority topics and the accompanying research questions is to help guide research on pregnancy, postpartum, and parenting in the context of substance use and recovery from substance use disorders (SUD). The intended audience for this document is researchers who work in the fields of medicine, public health, social work, parenting, SUD treatment, child welfare, and the intersections of these fields to conduct research that aligns with the needs and experiences of parents who use substances or have a history of substance use. In addition to broad categories for additional scientific inquiry, this document is specifically attuned to understanding and addressing stigma, racism, and other forms of discrimination that people who are currently using or are abstinent from substances may encounter.

These research priorities were created by the Center on Parenting and Opioids Community Professional Advisory Board. The board comprises community professionals who provide services and care for parents with SUD. This is a living document and this version was finalized in March 2025.

Approach

Rationale

More than 100 million children in the United States live with a parent who uses substances and nearly 7 million children live with a parent with SUD (Ghertner, 2022; see Table 1). Many of these families engage with professionals in the healthcare system, child welfare system, and/or criminal justice system, requiring an interdisciplinary team of professionals who work with parents who use substances to identify research opportunities among this population.

Parenting in the context of substance use predominately impacts White families in the United States but spans all demographics (Farahmand et al., 2020; see Table 2). However, Indigenous and Black families are more likely to receive punishment instead of treatment compared to White families (American Society of Addiction Medicine, n.d.; Simon et al., 2020). Given the large number of parents who use substances and the complex nature of navigating several disconnected systems of care, it is imperative to enhance understanding of the needs of this population and ways to improve services through research.

Table 1

Estimated Number and Percentage of Children Living with A Parent Who Used a Substance or Had a Substance Use Disorder in the Past Year, by Substance, Annual Average 2015–2019

Substance	Use		Use Disorder	
	Number	Percentage	Number	Percentage
Any substance	119,454,461	89.4%	7,054,936	1.9%
Alcohol	97,827,779	73.2%	4,978,793	6.6%
Cannabis	16,288,364	12.2%	869,864	0.8%
Opioids	5,591,554	4.2%	724,738	0.7%
Stimulants	3,292,091	2.5%	636,599	0.6%
Hallucinogens	944,747	0.7%	40,808	<0.1%
Other substances	806,548	0.6%	94,494	0.1%

Note. Table adapted from Ghertner, R. (2022). *U.S. National and State Estimates of Children Living with Parents Using Substances, 2015–2019*.

<https://aspe.hhs.gov/sites/default/files/documents/f34eb24c1aff645bed0a6e978c0b4d16/children-at-risk-of-sud.pdf>. Source: National Survey of Drug Use and Health, 2015–2019. N (respondents)=86,215, N (children)=163,121. —

Table 2**Number and Percentage of Children Living with A Parent Who Used a Substance or Had a Substance Use Disorder in the Past Year, by Demographics, Annual Average 2015–2019**

Child Characteristic	Use		Use Disorder	
	Number	Percentage	Number	Percentage
Age				
Age <3	3,976,686	19.0%	377,539	1.9%
Age 3–5	4,200,876	18.6%	424,915	2.5%
Age 6–11	7,453,027	16.3%	440,956	2.4%
Age 12–17	5,998,775	13.5%	666,435	1.8%
Race and Ethnicity				
American Indian/Alaska Native, non-Hispanic	273,450	32.9%	54,706	8.0%
Asian, non-Hispanic	402,765	5.0%	22,582	0.4%
Black, non-Hispanic	3,197,123	19.9%	287,763	2.2%
Hawaiian or Pacific Islander, non-Hispanic	117,289	16.7%	23,733	4.0%
White, non-Hispanic	13,556,620	17.9%	1,263,530	2.1%
More than one race, non-Hispanic	512,945	26.9%	48,317	3.1%
Hispanic, any race	3,566,490	11.8%	375,513	1.6%
Geographic Location				
Urban	17,889,398	16.4%	1,698,604	2.0%
Rural	3,737,284	15.2%	1,263,530	2.1%

Note. Table adapted from Ghertner, R. (2022). *U.S. National and State Estimates of Children Living with Parents Using Substances, 2015–2019.*

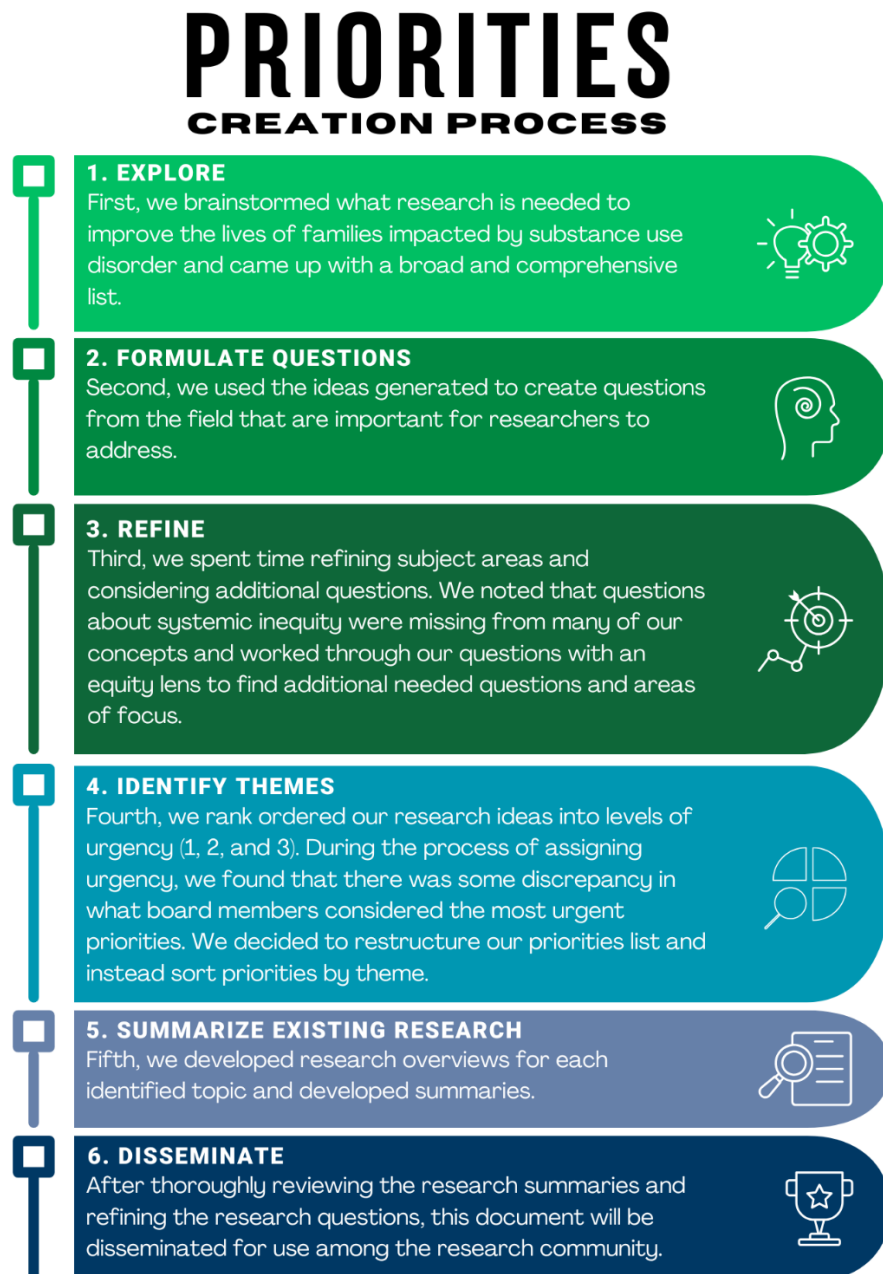
<https://aspe.hhs.gov/sites/default/files/documents/f34eb24c1aff645bed0a6e978c0b4d16/children-at-risk-of-sud.pdf>. Source: National Survey of Drug Use and Health, 2015–2019. N (respondents)=86,215, N (children)=163,121.

Methods

We leveraged elements from the Justice Involved and Emerging Adult Populations (JEAP) initiative’s guide for co-creating research priorities alongside our Community Professional Advisory Board (JEAP Initiative, 2022). We convened 6 meetings between July 2023 and May 2024. Figure 1 articulates details on our approach to developing priorities for future research at the intersection of parenting and SUD.

Figure 1

Research Priorities Creation Process



Equity and Intersectionality

Economic vulnerability and class-based discrimination increase the likelihood of involvement with the child welfare system and can inhibit reunification of children and their parents (Child Welfare Information Gateway, 2021; Webb et al., 2020). Family separation can be difficult to navigate and can cause parents to incur unexpected costs, such as required parenting classes and child support. These classes, among other interventions designed for parents who have been separated from their children, may not be evidence-based or culturally appropriate, and may not improve parenting practices (Shapiro et al., 2024). They may also lack acceptability to parents, which is an upstream driver of program completion and effectiveness (Giannotta et al., 2019). In addition, confusion while navigating these systems may cause parents to lose hope that they will be reunited with their children, resulting in poorer mental health outcomes, increases in self-harm and suicide, increases in substance use, and lower motivation for substance use treatment (Darlington et al., 2023).

Black and Indigenous children are overrepresented in the child welfare system (Child Welfare Information Gateway, 2021). Black and Indigenous people experience stigma, racism, poverty, a lack of cultural understanding in care settings, and pervasive effects of current, generational, and historical trauma. This confluence of factors presents barriers for Black and Indigenous pregnant people to access high-quality care, especially when they use substances. Although some steps have been taken to reduce the harms of child welfare system involvement on Indigenous children, such as the passage of the Indian Child Welfare Act, Indigenous children are still disproportionately impacted by poverty and are more likely to live in communities with high rates of SUD than children of others (US Department of the Interior, n.d.). Black birthing parents and their babies are more likely to be drug tested in medical settings and referred to child welfare than their White counterparts (Schoneich et al., 2023; Wakeman et al., 2022). Urine drug testing and criminal justice systems involvement disproportionately harm Black communities and perpetuate further inequity by disrupting family bonds and limiting access to employment, financial assistance, and other social services.

Parents' gender identity also intersects with their substance use, parenting identity, and access to services. Mothers reported that they felt their substance use was more stigmatized than fathers' substance use (Darlington et al., 2023). Sexism creates barriers to accessing healthcare for female-presenting patients (Rapp et al., 2022). Transgender and nonbinary people experience discrimination frequently in healthcare settings (Durocher & Caxaj, 2022). Gender identity can intersect with other marginalized identities to increase an individual's risk of experiencing discrimination, such as those with minoritized racial and ethnic identities, experiencing economic instability, who are non-English speaking, and living with disabilities (Kattari et al., 2021).

With these considerations in mind, we urge those who interact with this priorities document to keep in mind the intersectional identities held by parents with SUD and their family members.

We also posit that careful consideration of these intersecting identities emphasizes the need to go beyond addressing individual risks and to specifically change the systems that interfere with recovery and make stability more challenging for families. Additionally, to reach parents from diverse backgrounds, those who will benefit from services should be centered in service design including consideration of offering services in multiple languages, in settings that are accessible to minoritized communities, and at no or low cost.

Research Priority Topics

Topic 1: Family Separation and Other Family Challenges

Ample research has demonstrated associations between child/parent separation and child outcomes, but far less research has examined the associations between child/parent separation and parent outcomes (Broadhurst & Mason, 2017; Darlington et al., 2023). One of the few studies that focused on parental outcomes found that mothers who lose custody of their children experience the following: high rates of mental illness, increased substance use, loneliness, internalization of the “unfit parent” identity, and apathy about their own well-being (Darlington et al., 2023). In the years following custody loss, mothers experienced significantly higher rates of depression, anxiety, and psychiatric hospitalizations than mothers who retained custody of their children. Rates of co-occurring mental illness are high among people with SUD and most do not receive treatment for both conditions (Substance Abuse and Mental Health Services Administration, 2024). Some mothers reported that the separation from their children caused their substance use to increase because they had decreased motivation to abstain from substance use if they could not be with their children (Darlington et al., 2023). They additionally reported using substances in more dangerous ways, such as in isolation, in order to hide their use from child welfare and because the mental health challenges posed by child removal made them apathetic about their own health and well-being.

Moreover, when a child is removed at birth, both the birthing parent and the newborn child lose out on medical benefits associated with skin-to-skin contact, including improved sleep and lactation (Patriksson & Selin, 2022). In some instances, child removal may be prevented by systems of care and/or by family members who agree to care for the child to prevent their entry into the child welfare system. While kinship care may allow parents to have more access to their child than they would otherwise have, the experience of loss of parental rights and separation remains a challenge.

Summary and recommendation: Research is needed to identify effective methods to prevent family separation and promote reunification when preventing separation is impossible. The effects of separation on parent outcomes should continue to be investigated, particularly among marginalized communities.

Topic 2: Grief and Loss

Parents with SUD experience repeated losses in multiple forms. Parents who lose custody of their children report grieving the loss of their children while simultaneously grieving the loss of their parental identity (Darlington et al., 2023). Some also feel unsupported during this grieving period because their loved ones did not express sympathy for this loss and the social services that had previously been available to them when the child was in their custody were removed. Grief may make it more challenging to refrain from using substances, exacerbate current use, or cause people to engage in more risky use.

In addition to grief associated with child removal, pregnancy loss is an experience that occurs in at least 15% of known pregnancies among the general population (Quenby et al., 2021). Not only is there a general oversight and dearth of services for families who experience pregnancy loss or the death of a baby (Hennessy & O'Donoghue, 2024), but also birthing parents who used substances during pregnancy are often met with discrimination and punishment rather than compassion (The Center for Child Health Policy, n.d.).

Loss and the grief that follows also impacts loved ones of those who use substances. The loss of a loved one from overdose is confusing and painful, especially for children. The loss of a relationship when a parent has not been involved can create additional grief from the loss of a relationship that was hoped for but not available. Families affected by intimate partner violence may have to cope with the loss of the intimate partnership and the loss of a parenting relationship if the perpetrator of the violence is unable to engage with the family. There are few resources to support families with these specific experiences.

Racial inequities persist in maternal mortality such that Black and Indigenous pregnant people die from conditions associated with pregnancy at significantly higher rates than White, Hispanic, and Asian/Pacific Islander pregnant people (Petersen, 2019).

Summary and recommendation: Research is needed to develop and equitably disseminate interventions that address grief among parents who experience pregnancy loss, child death, and removal. Similarly, research is needed for families who experience the death of loved ones due to overdose. Interventions to reduce maternal mortality must be disseminated and implemented equitably to reduce racial disparities. Additional research is needed to understand the disproportionate burden due to racial discrimination during childbirth among those with SUD and their infants. There is additional research needed to understand best practices for enhancing services and equitably disseminating effective practices to prevent mortality.

Topic 3: Non-Birthing Parents

Fathers/non-birthing parents with SUD who are the primary or sole caretaker of their child may experience additional barriers to gaining and retaining the rights to parent their child.

Fathers/non-birthing partners are also vulnerable to heightened mental health challenges during and following pregnancy (Lee et al., 2021). The majority of parenting interventions have been tested with mothers, thus, fathers/non-birthing parents may not receive proportional benefits from these interventions (Cioffi et al., 2023; Cioffi & DeGarmo, 2021; Henry et al., 2020). Quality father involvement is beneficial to children regardless of whether a father lives with their child (Adamsons & Johnson, 2013). Fathers from marginalized communities, such as Black and Indigenous fathers experience additional barriers to custody because of stereotypes and bias, despite having similar levels of involvement and providing a similar quality of care to their children as White fathers (Dettlaff et al., 2020; Fagan, 2024).

Fathers may feel unprepared for their role as a parent due to trauma that they have experienced and/or a lack of positive parental role models. Fathers' capacity to parent changes over time, depending on the parents' life circumstances and the needs of the child, but feeling incapable at any time can be difficult as a parent. This may cause the father to remove themselves from the child's life, which can spur feelings of grief over the loss of their role as a parent and resentment from the birthing parent. The birthing parent may also restrict the other parent's access to the child, leading the other parent to grieve their role as a parent because they are separated from their child. Fathers may also experience structural barriers to caring for their children, such as custody loss or incarceration.

Summary and recommendation: Researchers and care providers should consider the ways that fathers/non-birthing parents are discussed to avoid reinforcing negative stigma against them (Lipsett et al., 2023). When fathers/non-birthing parents feel incapable of parenting, providers should focus on affirming the importance of the parenting role and identity, building their capacity to parent, and reducing barriers to parenting (Cioffi & DeGarmo, 2021; Degarmo, 2010). Research is needed to identify best practices for engaging fathers in the parenting process and services that are designed to meet the needs of fathers. Additional research is needed to similarly understand the needs for services for non-birthing parents who do not identify as fathers.

Topic 4: Family Relationships and Kinship Care

Relationships among caregivers are frequently neglected in SUD treatment settings and parenting services. Couples therapy and treatment are often difficult to access. When services are available, approaches to couples' treatment for SUD must understand the complexities of instances where intimate partner violence may be present or when one partner is using substances while the other is working toward abstinence. Additionally, pressure to leave or separate may deter women and other partners who experience violence from engaging with care. Stigma of perpetrating intimate partner violence may inhibit parents in need of SUD treatment from seeking it (Overstreet & Quinn, 2013). Providing effective treatment for intimate partner violence perpetrators rests on a foundation of understanding that all people are capable of making positive changes and repairing harmful patterns perpetuated in families. This does not mean promoting family unity at all costs, but instead means providing services to all family members that align with their respective needs and goals and not excluding a partner who is perpetrating violence out of the belief that they are incapable of changing. There are few interventions that effectively address intimate partner violence among parents who use substances, although there is evidence to suggest that such interventions are feasible and improve the parent's relationship with their child (Stover, 2013, 2015).

Navigating the foster care system can be complex and confusing for people providing relative care. Caregivers may have difficulty enrolling children in necessary services such as healthcare or the school system and may not receive adequate information about what is happening with a child's case. Caregivers may also not have appropriate information to make decisions for the child they are caring for, such as information about psychiatric medications that the child needs. It can be especially difficult for kinship placement because the foster care training may be different or non-existent. When training is available, it may be time intensive and/or stigmatizing. Systematic discrimination and stigmatization may also impact kinship care placements through stigmatization of family members for their past decisions (e.g., past criminal legal involvement of a relative who is in recovery may prevent them from providing kinship care).

Summary and recommendation: Interventions among parents who use substances should focus on improving the relationship between caregivers, focusing on potential for positive change with the application of evidence-based, person-centered services. Services to ease the burden of kinship care among families affected by SUD are needed to provide higher quality care for children and prevent the perpetuation of stigma and discrimination in the child welfare system.

Topic 5: Systems Improvement

Medical settings are often experienced as unwelcoming by people who use substances. In addition to being a site of discrimination and stigma, especially for people with marginalized identities, healthcare institutions can be a referral point to punitive systems such as criminal justice and/or child welfare (Roberts et al., 2021). Racial/ethnic disparities persist in access to medication for opioid use disorder for pregnant people with opioid use disorder, even though agonist medication is the best practice standard treatment for opioid use disorder (Wakeman et al., 2022). Healthcare professionals may misunderstand and overstate the effects of prenatal substance exposure and falsely or disproportionately blame pregnant people for complications experienced before and after birth, while dismissing the structural barriers and exposures that also contribute to suboptimal health outcomes (Roberts et al., 2021).

Because access to healthcare is essential for pregnant people, research in this area should focus on promoting harm reduction, ensuring that the built environment and organizational culture is welcoming to all patients and that care is accessible, acceptable, and affordable to people who use substances. Healthcare professionals may damage therapeutic relationships by perpetuating harmful myths about substance use being immoral (Hawk et al., 2017) and interactions with child welfare may cause parents who use substances to internalize the “unfit parent” identity (Darlington et al., 2023), both of which can be detrimental to the parent-child relationship. Child removal is also associated with decreased duration of time between births, which can carry medical risks to the birthing person (Reddy et al., 2024).

Punitive policies for substance use during pregnancy may cause some pregnant people to delay or avoid seeking prenatal care (Roberts et al., 2021). Media depicting pregnant people who use substances as bad parents, particularly when those parents are not White (e.g., “crack baby” racist media), has led many people to believe that the effects of substance use on pregnant people and developing fetuses are more pronounced than research has shown (Habib et al., 2023). Public and parent perceptions are often misaligned with the available data on associations between prenatal substance exposure and long-term outcomes, with effects of legal substances often being underacknowledged and effects of illicit substances being overemphasized, especially when considering the lack of rigorous evaluation data (Chang, 2020). This misunderstanding stems from a historical focus on individual behavior (i.e. pregnant person’s substance use) that ignores the unpredictable nature of every pregnancy, the lack of structural supports available to pregnant people, and the barriers related to racism in the US.

Summary and recommendation: Messaging to parents about the effects of substance use during pregnancy must be communicated honestly and in a non-judgmental way. When prenatal substance exposure does impact child development, it is important that parents are informed of interventions available to them to facilitate early engagement with services and ensure that parents are included in these interventions to the extent possible. It is equally

important to inform parents that the causes of developmental delay are not always clear and that delays can occur for a variety of reasons, even among children who were prenatally exposed to substances. Healthcare providers also need information on SUD to avoid perpetuating stigma and discrimination when pregnant people who use substances seek care. Healthcare workers who are educated about substance use during pregnancy and the structural barriers that exist for pregnant people who use substances should intervene to provide early and intensive supports to prevent family separation among their patients, when possible. Best practices should be identified for providing families affected by substance use with accurate and timely education about prenatal care, prenatal exposures, family planning, and treatment options in a non-stigmatizing, culturally appropriate, and equitable way.

Research Questions Aligned with Topical Priorities

Topic 1: Family Separation and Other Family Challenges

Understanding the Impacts of Family Separation and Other Family Challenges

1. What is the impact of family/child separation on the birthing parent's healing postpartum?
2. What are the physiological and developmental impacts of separation immediately following birth for children, birthing people, and non-birthing partners?
3. Does family separation impact parent substance use, and in what ways?
4. Are there intergenerational effects of family separation?
5. What are the effects of family separation on other children in the birth home?
6. Do outcomes differ based on where a child goes after they are removed from the home?
7. What is the impact of family separation on the intergenerational transmission of cultural practices?
8. Does the criminalization of substance use exacerbate the impacts of family separation, and in what ways?
9. Does child welfare involvement play a role in criminal legal system proceedings and investigations by law enforcement?
10. Does child welfare involvement play a role in Immigration and Customs Enforcement investigations?
11. How do inequities in reunification rates affect parents' outlook on and participation in child welfare systems involvement? How do these inequities influence care-seeking behaviors by parents for themselves and for their child, specifically during the prenatal period?
12. What is the prevalence of mental health concerns among parents with SUD? Are there specific mental health needs among parents with SUD that are different from the general populations of people with SUD or parents without SUD?
13. What are the cumulative effects of repeated separations on parents?

Improving Services to Prevent and Address Family Separation

1. What strategies can healthcare institutions use to prevent family separation?
2. How does family separation impact the social services and economic assistance available to parents?
3. What are the best ways to engage pregnant people and their partners in parenting-specific services to prevent removal?
4. What are the best ways to engage pregnant people and their partners in parenting-specific services to promote reunification with other children?

5. What are the best practices for addressing economic challenges among families impacted by SUD?
6. What are the barriers to receiving needed and wanted mental health services for parents with SUD?
7. What are the barriers to receiving support and reunification when a parent was placed in state custody as a child?
8. How can interventions for parents with SUD be designed for low-resource settings to promote uptake and reach?

Topic 2: Grief and Loss

Understanding Experiences of Grief and Loss

1. What are the experiences and needs of families who experience pregnancy and infant loss?
2. How do the needs and experiences of families who experience pregnancy and infant loss differ for those with marginalized identities?
3. What are the community-level impacts of inequitable maternal mortality rates?
4. Is loss of parental identity associated with increased, continued, or more often returning to substance use?
5. Are there ways to maintain parental identity for parents who are prevented from or otherwise unable to parent their child?
6. When parents die by overdose, suicide, or substance use-related health conditions, what are ways to support family members who are impacted by the loss, including children?

Supporting Families During and Following Grief and Loss

1. What are the best practices for supporting parents who are experiencing grief, and are there different best practices depending on the experience associated with grief (e.g., pregnancy and infant loss including abortion, infant death, child removal, death of other loved ones, incarceration, or other legal barriers)?
2. How can interventions to prevent maternal deaths among Black and Indigenous birthing parents be disseminated equitably?
3. What are the best strategies to facilitate the implementation of interventions to prevent maternal deaths among Black and Indigenous birthing parents?
4. How can grief services be delivered in a way that is culturally appropriate, including the culture of people who use substances?

Topic 3: Non-Birthing Parents

Understanding the Experiences of Non-Birthing Parents, including Fathers

1. What are the needs of non-birthing parents with SUD, including fathers?
2. What barriers limit non-birthing parents' access to services?
3. What is the impact of misinformation about the effects of substance use on pregnancy/parenting on caregiving behaviors?

Supporting Non-Birthing Parents, including Fathers

1. What strategies could be used to address disparities in access to services for non-birthing parents with marginalized identities?
2. What supports are needed around grief and trauma when the non-birthing parent voluntarily excludes themselves from their parenting role?
3. How can services be responsive to non-birthing parents' changing capacity to parent over time?
4. How can service providers help non-birthing parents evaluate their own capacity to parent?
5. What are the best ways to provide comprehensive support for the entire family when both parents use substances? When one parent uses substances? In multigenerational households where one or more members use substances?

Topic 4: Family Relationships and Kinship Care

1. When a non-birthing parent is involuntarily excluded from parenting, what supports are needed to repair the relationship with the birthing parent and/or regain access to the child through welfare systems?
2. How can people who are typically excluded from services (e.g., perpetrators of intimate partner violence and incarcerated parents) be engaged in services without causing them additional harm?
3. What services are needed for couples who use substances and how can these services be adapted for partnerships affected by intimate partner violence?
4. What are the best ways to support kinship caregivers, guardians, and foster parents who are caring for children whose parents use substances?
5. What strategies can service providers use to educate foster families about the importance of maintaining/building relationships between children and their birth families to prepare birth families for reunification?
6. How can foster families be motivated to promote reunification and relationship building between a child and their birth family? What can they do to promote reunification and relationship building between a child and their birth family?

7. If a non-birthing parent is incarcerated, what strategies can service providers use to facilitate a relationship between that non-birthing parent and their child when one is desired?
8. If a birthing parent is incarcerated, what strategies can service providers use to facilitate a relationship between that birthing parent and their child when one is desired?
9. What are specific challenges for older adults assuming a parenting role for their non-biological children?

Topic 5: Systems Improvement

Systems Improvement

1. What are best practices to support the de-implementation of policies and practices that disproportionately harm marginalized communities?
2. How can racial disparities in prenatal drug screening and referrals to child welfare during pregnancy be eliminated?
3. What policies can address barriers to accessing health insurance and necessary health services for parents with SUD and their children?
4. What training, intervention, and/or enforcement do providers need to provide nonjudgemental care?
5. What are best practices for integrating peer support workers in healthcare systems as a non-judgmental point of contact to promote improved implementation and effectiveness of best practices?
6. What strategies can support equitable selection and implementation of evidence-based treatments for parents with SUD?
7. What are the best strategies to ensure that evidence-based, trauma-informed services are provided that do not perpetuate blame among survivors of all types of traumas, including medical trauma and birth trauma?
8. What strategies can service providers use to personalize the trauma-informed services they provide?
9. What are the best strategies for service providers to elicit a family's needs and provide services that align with those needs?
10. How do we ensure that consent and autonomy are guaranteed for parents when they do not speak English or experience other communication barriers such as impaired vision and/or hearing or literacy challenges?
11. How can services be adaptive to the changing needs of families as their child ages?

Health Education

1. What are the most affirming, effective ways to provide education on birth control and family planning to families impacted by SUD?

2. Do providers have accurate information about the real and perceived impacts of prenatal substance exposure?
3. How can parents receive accurate information about how to support their child's health if there are potential long-term effects of prenatal substance exposure without guilt and shame that would deter them from taking action?
4. How can parents receive accurate information about what to do to support their own health if there are potential long-term effects of substance use during pregnancy without guilt and shame that would deter them from taking action?

Encouraging Engagement

1. What are best practices for making services more welcoming and inviting for parents with SUD?
2. What are effective approaches to increase experiences of safety and welcoming during healthcare visits?
3. What are the best strategies for building trust between providers and patients from marginalized communities?
4. What are the best strategies for engaging parents from economically disadvantaged backgrounds?
5. How can service providers reduce barriers to parenting and reunification among parents who earn low wages, labor without benefits, labor without consistency, and/or experience a lack of opportunity for additional skills development?
6. How can systems of care be more integrated to facilitate engagement?
7. What system strategies could be used to increase access to education and other support for pregnant people with SUD alongside their non-birthing partners, particularly those from traditionally marginalized communities?

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