APRIL 2025 • ISSUE NO. 184

Adoption Advocate

Prenatal Drug Exposure and Adoption

BY ELISA ROSMAN, PhD, MA

National Council For Adoption
431 North Lee Street
Alexandria, Virginia 22314

AdoptionCouncil.org
ncfa@adoptioncouncil.org
(703) 299-6633

Prenatal Drug Exposure and Adoption

BY ELISA ROSMAN, PhD, MA

Introduction

For many parents considering adoption, the idea of adopting a child who has been exposed to drugs prenatally presents one of the greatest potential challenges, along with the most unknowns. Previously, the idea of the "crack baby"—and the myths and misperceptions that accompany it—loomed large in popular culture. Recently, opiate use and addiction have risen dramatically in this country. Opioid deaths have increased tenfold over the past 25 years, and opioids killed an average of 225 people daily in 2022.[1] Accordingly, concern has turned to prenatal opiate exposure, which occurs when pregnant women use hydrocodone (Vicodin), oxycodone (OxyContin), codeine, morphine, heroin, fentanyl, methadone, and suboxone. As the organization Creating a Family acknowledges, "Adopting or fostering an opiate-exposed baby is scary for most parents to consider."[2]

As an adoptive parent or prospective adoptive parent, what does the rising concern about opiate addiction mean for you? What do you need to know when considering a potential match with a birth mother who might have known opiate use? Unfortunately, the answer is not immediately clear, and the media often only makes this more confusing. Dr. Joshua Sharfstein, speaking on an episode of NPR's All Things Considered,[3] explained how media portrayals can cause a false understanding of the impact of addiction:

"We certainly should learn the lessons of what I would call the 'crack baby panic.' There were magazine covers, newspaper stories [about] what was happening to the brains of these babies. Would they be permanently scarred?

1 USAFacts. (2024). *The opioid crisis in data*. https://usafacts.org/articles/opioid-addiction-deaths-and-treatment-latest-analysis-data/

2 Creating a Family. (2018, May 21). *What you must know when adopting or fostering an opiate-exposed baby*. https://creatingafamily.org/adoption-category/adopting-an-opiate-exposed-baby/

3 Siegel, R. & Cheung, J. (Hosts). (2017, June 30). For newborns exposed to opioids, health issues may be the least of their problems [Audio podcast episode]. In All Things Considered. NPR. https://www.npr.org/sections/health-shots/2017/06/30/534911289/for-newborns-exposed-to-opioids-health-issues-may-be-the-least-of-their-problems

The long-term evidence is it really doesn't look like there's much of anything from cocaine in terms of chemical impact on the brain."

"Every new parent wants a child that is happy and healthy, but opioid addiction and other drug use by a birth mother during pregnancy is something that makes many adoptive parents wary, and with good reason. However, the fact is many birth mothers choose adoption because their life situation makes parenting a child impossible or difficult. Often, the life situation can be traced back to drugs and alcohol."[4]

Are recommendations clearer with the shift from cocaine to opiates? Unfortunately, not much. Researchers often reach conflicting conclusions. Some of this is because research studies do not use large enough sample sizes or use too many variables to have meaningful findings. In addition, a great deal of the research literature assumes that the child is being raised by the parent with the addiction, making it difficult to disentangle the impact of prenatal exposure from the impact of continued exposure to parenting impacted by a substance use disorder. Dr. Sharfstein goes on to explain, "It's really the home they go into that's more important than the short duration of withdrawal symptoms."[5]

This article hopes to present what is known from the research literature. It includes information about basic terminology and definitions, what an infant's experience

As an adoptive parent or prospective adoptive parent, what does the rising concern about opiate addiction mean for you?

of withdrawal might look like, the types of needs a child might have as they grow, and services that families can access to address those needs. This article shares not only what challenges children and families might face, but also how those challenges can be ameliorated by accessing services, supports, and resources.

What the Research Says

What is the basic terminology we need to know?

The term "substance use disorder," or SUD, is currently used to cover a wide range of issues and can include recurrent use of alcohol and both legal and illegal drugs. When women use opioids during pregnancy, the unborn child experiences prenatal opioid exposure (POE), and the newborn can experience withdrawal shortly after birth. According to the American Academy of Pediatrics (AAP), this withdrawal is sometimes referred to in the literature as neonatal abstinence syndrome (NAS) and sometimes as neonatal opioid withdrawal

[4] A Child's Hope. (2018, August 21). *Opioid addiction and adoption – what waiting parents need to know*. https://achildshope.com/opioid-addiction-and-adoption/

[5] Siegel, R. & Cheung, J. (Hosts). (2017, June 30). For newborns exposed to opioids, health issues may be the least of their problems [Audio podcast episode]. In *All Things Considered*. NPR. https://www.npr.org/sections/health-shots/2017/06/30/534911289/for-newborns-exposed-to-opioids-health-issues-may-be-the-least-of-their-problems

syndrome (NOWS).[6,7] Pregnant women with opioid use disorder may receive medication assisted therapy (MAT) during pregnancy. The term opioid use disorder (OUD) also appears in the literature.

How many babies are actually impacted?

The CDC shares information on opioid use during pregnancy: "According to 2019 self-reported data, about 7% of women reported use of prescription opioid pain relievers during pregnancy. Of those, 1 in 5 reported misuse."[8] From 2010 to 2017, the estimated rate of NAS increased from 4.0 per 1,000 births to 7.3 per 1,000 births, and maternal opioid-related diagnoses increased from 3.5 to 8.2.[9] There is a large variation depending on your location in the United States. For example, Nebraska reported 1.3 cases of NAS per 1,000 births, while West Virginia reported 53.5. This interactive map[10] from the Healthcare Cost and Utilization Project shares NAS rates by state.

...babies can present with different symptoms of NOWS depending on what type of opioid the mom used, when in the pregnancy the drug use occurred, and whether the mom also used other substances.

What does NAS/ NOWS actually look like in newborns?

The first and most important piece of information to remember is that NOWS is treatable. Also, multiple factors can impact what NOWS looks like in a baby. According to the AAP, babies can present with different symptoms of NOWS depending on what type of opioid the mom used, when in the pregnancy the drug use occurred, and whether the mom also used other substances. Women who use opioids are more likely to concurrently use other substances, which can further complicate the severity of NOWS in the newborn.[11]

The timing of NOWS also varies. For some infants, withdrawal symptoms may not occur until five to seven days of age, at which time many infants have already been discharged from the hospital.

---

6 Since both are used in the literature, this article also uses both, often depending on which term was used in the research being cited.

7 Patrick, S.W., Barfield, W.D., Poindexter, B.B., Committee on Fetus and Newborn, Committee on Substance Use and Prevention, Cummings, J., Hand, I., Adams-Chapman, I., Aucott, S.W., Puopolo, K.M., Goldsmith, J.P., Kaufman, D., Martin, C., Mowitz, M., Gonzalez, L., Camenga, D.R., Quigley, J., Ryan, S.A., & Walker-Harding, L. (2020). Neonatal opioid withdrawal syndrome. *Pediatrics*, *146*(5). https://doi.org/10.1542/peds.2020-029074

8 Centers for Disease Control and Prevention. (2024). *About opioid use during pregnancy*. https://www.cdc.gov/opioid-use-during-pregnancy/about/index.html

9 Hirai, A.H., Ko, J.Y., & Owens P.L. (2021). Neonatal abstinence syndrome and maternal opioid-related diagnosis in the US, 2010–2017. *JAMA*, *325*(2), 146–155. https://doi.org/10.1001/jama.2020.24991

10 Agency for Healthcare Research and Quality. (2024, December). *HCUP fast stats: Neonatal Abstinence Syndrome (NAS) among newborn hospitalizations*. https://datatools.ahrq.gov/hcup-fast-stats/?tab=special-emphasis&dash=83

11 Patrick, S.W., Barfield, W.D., Poindexter, B.B., Committee on Fetus and Newborn, Committee on Substance Use and Prevention, Cummings, J., Hand, I., Adams-Chapman, I., Aucott, S.W., Puopolo, K.M., Goldsmith, J.P. Kaufman, D., Martin, C., Mowitz, M., Gonzalez, L., Camenga, D.R., Quigley, J., Ryan, S.A., & Walker-Harding, L. (2020). Neonatal opioid withdrawal syndrome. *Pediatrics*, *146*(5). https://doi.org/10.1542/peds.2020-029074

The AAP shares the following signs of NOWS:[12]

Central nervous system irritability

- High-pitched continuous crying
- Decreased sleep
- Tremors
- Increased muscle tone
- Hyperactive Moro reflex[13]
- Seizures

Autonomic nervous system activation

- Sweating
- Fever
- Frequent yawning and sneezing
- Increased respiratory rate
- Nasal stuffiness and flaring

Gastrointestinal dysfunction

- Feeding difficulties
- Vomiting
- Loose or watery stools

How does the hospital officially diagnose if a baby has NAS?

If your baby is being evaluated for NAS, you are most likely to hear hospital staff refer to the Finnegan tool, which was first developed in the 1990s and has been modified several times over the years.[14] The modified Finnegan tool evaluates 21 of the most common symptoms and assigns a score based on how severe those symptoms are in the baby. A score above eight is considered high. These scores are used to determine when the baby can stop receiving morphine. You can review an example of the scoring sheet, as used by the Kentucky Department for Community Based Services.

A newer tool that you may encounter is the Eat, Sleep, Console (ESC) Approach,[15] which is guided by the infant's clinical symptoms. It is much simpler than the Finnegan tool and focuses specifically on the infant's behavior. ESC looks at the following three questions: does the infant eat an age-appropriate amount, sleep a developmentally appropriate amount of time, and console within a typical amount of time? Some research has found that using the ESC Approach is associated with infants being less likely to be treated with morphine and being discharged from the hospital quicker.[16]

Researchers are also exploring a range of other alternatives to the Finnegan assessment. These include exploring the skin-conductance of opioid-exposed infants, measuring pupillary diameter, and measuring alterations in sleep states.[17] While none of these have become accepted as standard, they may represent future areas of research and practice.

As guidance from the AAP explains, it does not

---

12 Ibid.

13 The Moro reflex is an involuntary startle response.

14 Finnegan, L.P., & Kaltenbach, K. (1992). Finnegan neonatal abstinence scoring–Neonatal abstinence syndrome. In R. A. Hoekelman, S.B. Friedman, N. M. Nelson, et al. (Eds.), *Primary pediatric care* (2nd ed.; pp. 1367–1378). Mosby.

15 Young, L. W., Ounpraseuth, S. T., Merhar, S. L., Hu, Z., Simon, A. E., Bremer, A. A., Lee, J. Y., Das, A., Crawford, M. M., Greenberg, R. G., Smith, P. B., Poindexter, B. B., Higgins, R. D., Walsh, M. C., Rice, W., Paul, D. A., Maxwell, J. R., Telang, S., Fung, C. M., … Devlin, L. A. for the ACT NOW Collaborative. (2023). Eat, Sleep, Console approach or usual care for neonatal opioid withdrawal. *The New England Journal of Medicine, 388*(25). https://doi.org/10.1056/NEJMoa2214470

16 Grossman, M. R., Berkwitt, A. K., Osborn, R. R., Xu, Y., Esserman, D. A., Shapiro, E. D., & Bizzarro, M. J. (2017). An initiative to improve the quality of care of infants with neonatal abstinence syndrome. *Pediatrics, 139*(6), https://doi.org/10.1542/peds.2016-3360

17 Schiff, D. M., & Grossman, M. R. (2019). Beyond the Finnegan scoring system: Novel assessment and diagnostic techniques for the opioid-exposed infant. *Seminars in Fetal & Neonatal Medicine. 24*(2), 115–120. https://doi.org/10.1016/j.siny.2019.01.003

necessarily matter which system the hospital uses, as long as everyone on the baby's team is working with the same information. "The AAP does not endorse one scoring system over another because there is not significant evidence to support one tool's superiority. However, given evidence to suggest that establishing a consistent protocol and approach to scoring improves outcomes, every hospital should have a written protocol and optimize provider adherence."[18]

How will the hospital manage NOWS?

If an infant is known to have been exposed to opioids, the AAP guidance states that the infant should be observed for at least three days to see if withdrawal symptoms develop.[19] Infants exposed to buprenorphine and sustained-release opioids should be observed for four to seven days, and infants exposed to methadone for five to seven days. While NOWS has traditionally been managed in the NICU, this is not always necessary. NOWS-related symptoms can often be managed in a traditional hospital room setting.

For some infants experiencing NOWS, medication is necessary, and morphine is used most often. However, several studies have found that short-term outcomes were actually better for babies who received methadone rather than morphine. One study found that, compared to morphine, methadone was associated with a 14% shorter hospital stay for the baby and a 16% shorter length of treatment time.[20] There is also ongoing research suggesting buprenorphine may be effective, especially if the mother was receiving it prenatally.[21] Sometimes an additional medication will be added to morphine, typically clonidine or phenobarbital.

While NOWS has traditionally been managed in the NICU, this is not always necessary. NOWS-related symptoms can often be managed in a traditional hospital room setting.

Research is emerging into ways to address NOWS without medication, but these approaches often explicitly include the birth mother (e.g., breastfeeding), which can provide an extra level of challenge in adoption. However, there are interventions that you, as the adoptive parent, can also do to help your baby during withdrawal. Creating a Family shares the following tips for helping your baby during withdrawal:[22]

---

18 Patrick, S.W., Barfield, W.D., Poindexter, B.B., Committee on Fetus and Newborn, Committee on Substance Use and Prevention, Cummings, J., Hand, I., Adams-Chapman, I., Aucott, S.W., Puopolo, K.M., Goldsmith, J.P., Kaufman, D., Martin, C., Mowitz, M., Gonzalez, L., Camenga, D.R., Quigley, J., Ryan, S.A., & Walker-Harding, L. (2020). Neonatal opioid withdrawal syndrome. *Pediatrics*, *146*(5). https://doi.org/10.1542/peds.2020-029074

19 Ibid.

20 Davis, J. M., Shenberger, J., Terring, N., Breeze, J. L., Hudak, M., Wachman, E. M., Marro, P., Oliveira, E. L., Harvey-Wilkes, K., Czynski, A., Engelhardt, B., D'Apolito, K., Bogen, D., & Lester, B. (2018). Comparison of safety and efficacy of methadone vs morphine for treatment of neonatal abstinence syndrome: A randomized clinical trial. *JAMA Pediatrics*, *172*(8), 741–748. https://doi.org/10.1001/jamapediatrics.2018.1307

21 Progeny Health. (2023). *Best practices for management of infants with Neonatal Opioid Withdrawal Syndrome.* https://www.progenyhealth.com/wp-content/uploads/ProgenyHealth_ClinicalGuidelines_NeonatalWithdrawal_11.17.23.pdf

22 Creating a Family. (2018, May 21). *What you must know when adopting or fostering an opiate-exposed baby.* https://creatingafamily.org/adoption-category/adopting-an-opiate-exposed-baby/

...there are interventions that you, as the adoptive parent, can also do to help your baby during withdrawal.

1. Decreasing external stimulation (a quiet environment with dark or dimmed lights)
2. Cuddling and rocking
3. Swaddling (often with arms or hands out of the wrapping)
4. Skin-to-skin contact (kangaroo care)
5. Nonnutritive sucking (pacifier)
6. Warmth of the environment
7. Infant massage
8. Waterbed (with the baby)

What happens when you leave the hospital?

According to the AAP, an infant who has had opioid exposure should be seen by the pediatrician within 48 hours of leaving the hospital.[23] You then may need to schedule pediatrician visits more frequently than you would for infants who did not experience exposure. Having an adoption-competent pediatrician can help make sure that your doctor is especially aware of whatever unique needs your child and family may face. Infants may also be sent home with medications in order to shorten hospital stays. It is crucial to ensure the right team is in place to handle the infant's needs both right after coming home from the hospital and moving forward. As Patrick et al. state, "Lastly, hospitals should ensure adequate handoffs and information transfer to postdischarge care providers, including, pediatricians, early intervention providers, and home-nurse visitation programs."

What will happen as my child gets older?

Unfortunately, there is no one guide or list that can lead parents through what to expect for their growing child. There are various findings in the research, and all children have their own unique journeys. However, research can provide guidelines for what to look for and what may be expected as these children grow. Oei and colleagues stress the importance of a child receiving a diagnosis early in order to receive the best possible care moving forward: "Attention needs to focus upon events after withdrawal. Recognizing that prenatal substance use has consequences beyond the neonatal period provides an enormous opportunity to support not only the infants, but their families and communities."[24]

A resource from Progeny Health provides a broad overview of what the research says about the impacts of NAS as children grow.[25] While some studies show lower cognitive abilities in elementary school and increased behavioral and academic problems, other studies show no neurological differences between exposed

---

[23] Patrick, S.W., Barfield, W.D., Poindexter, B.B., Committee on Fetus and Newborn, Committee on Substance Use and Prevention, Cummings, J., Hand, I., Adams-Chapman, I., Aucott, S.W., Puopolo, K.M., Goldsmith, J.P. Kaufman, D., Martin, C., Mowitz, M., Gonzalez, L., Camenga, D.R., Quigley, J., Ryan, S.A., & Walker-Harding, L. (2020). Neonatal opioid withdrawal syndrome. *Pediatrics*, *146*(5), https://doi.org/10.1542/peds.2020-029074

[24] Oei, J. L., Blythe, S., Dicair, L., Didden, D., Preisz, A., & Lantos, J. (2023). What's in a name? The ethical implications and opportunities in diagnosing an infant with neonatal abstinence syndrome (NAS). *Addiction*, *118*(1), 4–6. https://doi.org/10.1111/add.16022

[25] Progeny Health. (2023). *Best practices for management of infants with Neonatal Opioid Withdrawal Syndrome.* https://www.progenyhealth.com/wp-content/uploads/ProgenyHealth_ClinicalGuidelines_NeonatalWithdrawal_11.17.23.pdf

children and their peers. Research does show that infants who receive medication to treat their NAS have a higher risk of developing nystagmus.[26] Researchers have also found connections with prenatal opioid exposure and language delays and ADHD.

Similarly, Louw, in the introduction to the book *Neonatal Opioid Withdrawal Syndrome: Speech-Language Pathologists and Interprofessional Care*, reviews recent literature which finds that children with prenatal exposure may be at increased risk for a range of challenging outcomes, including "cognitive differences; developmental delays; speech and language delays; hearing disorders; mental health symptoms associated with attention deficit/hyperactivity disorder (ADHD); autism spectrum disorder (ASD); visual and motor impairments; poor academic performance from elementary through high school; and difficulties with literacy and math."[27] Additionally, infants with prenatal opioid exposure may have a higher incidence of cleft lip and palate.[28]

Some research focuses on specific sub-groups of children or specific services and interventions that might be helpful. Arter and her colleagues were interested in exploring whether there was a difference between children who had POE but not a NAS diagnosis and those who had POE and NAS. They found that children who were both exposed and had a diagnosis had more negative outcomes across the first three years of life. There

...some extra vigilance is required for needs to be addressed as children develop.

were also ongoing issues with growth and nutrition, and children who were exposed were found to have higher rates than their peers of hearing issues, developmental delay, and behavioral issues. "Given the growing incidence of prenatal opioid exposure and lack of knowledge regarding specific health and developmental outcomes during each year of life, it is imperative to explore age-specific outcomes so health care interventions and caregiver education can focus on the most pressing problems."[29]

Benninger and her colleagues' research focuses on outcomes in the speech/language domain.[30] They followed 202 infants with in-utero exposure to opioids and found that the infants in their sample, at one year, had lower scores in cognitive, language, and motor domains compared with scores for typically developing children. Focusing in on speech-language pathology, 11% of the children in their sample were referred to a speech-language pathologist before two years.

There is one critical takeaway to keep in mind when reviewing this research: since almost all of these studies are conducted with children being raised with their birth families, it is nearly

---

[26] Nystagmus is a condition where the eyes make rapid, uncontrollable movements.

[27] Louw, B. (2024). Introduction to Neonatal Opioid Withdrawal Syndrome (NOWS). In B. Louw (Ed.), *Neonatal Opioid Withdrawal Syndrome: Speech-language pathologists and interprofessional care* (1st ed.). Routledge. https://doi.org/10.4324/9781003397267

[28] Ibid.

[29] Arter, S., Lambert, J., Brokman, A., & Fall, N. (2021). Diagnoses during the first three years of life for children with prenatal opioid exposure and neonatal abstinence syndrome using a large maternal infant data hub. *Journal of Pediatric Nursing*, *61*, 34–39. https://doi.org/10.1016/j.pedn.2021.03.011

[30] Benninger, K. L., Richard, C., Conroy, S., Newton, J., Taylor, H. G., Sayed, A., Pietruszewski, L., Nelin, M. A., Batterson, N., & Maitre, N. L. (2022). One-year neurodevelopmental outcomes after neonatal opioid withdrawal syndrome: A prospective cohort study. *Perspectives of the ASHA Special Interest Groups*, *7*(4), 1019–1032. https://doi.org/10.1044/2022_PERSP-21-00270

impossible to parse the distinction between the oftentimes difficult circumstances of a child's environment and the lingering effects of in-utero opioid exposure. For example, in the study by Benninger above, they found that 53% of the moms in their sample also had a mental health condition.[31] Much of the research and literature in this area stresses the role of these contextual factors as children grow and develop and stresses the challenges these factors present. As an adoptive parent who may not be struggling with these issues, it will be necessary to help doctors and professionals disentangle some of these issues. This can be an instance where having an adoption-competent pediatrician can be especially valuable. A list of adoption-competent medical providers can be found here.

Perhaps the most important takeaway from this research is that some extra vigilance is required for needs to be addressed as children develop; perhaps regular visits with the pediatrician should occur more frequently to assess for developmental concerns and be able to address them as they emerge. Progeny Health shares the following types of follow-ups that could be helpful for infants who have been exposed prenatally:[32]

- Neurodevelopmental assessments to identify motor deficits and cognitive delays, performed by Early Intervention programs.
- Psycho-behavioral assessments to identify hyperactivity, impulsivity, and attention deficit in preschool-aged children, as well as school absence, school failure, and other behavioral problems in school-aged children.
- Ophthalmologic assessment due to an increased incidence of nystagmus and strabismus.[33]
- Awareness of the increased risk of ear infections.
- Development of a crying plan with parents to avoid Shaken Baby Syndrome.
- Awareness of the increased risk for Sudden Infant Death Syndrome (SIDS) and appropriate parental education.

Available Services for Your Child and Your Family

Post-discharge clinics

Once you have a pediatrician you trust, you can also look for a post-hospital discharge program in your area. For example, Johns Hopkins has a Neonatal Abstinence Syndrome Clinic. This clinic provides follow-up services at four, eight, and 18 months of age to provide specialized services related to NAS.

Early intervention

As your baby grows, if you and/or your pediatrician are concerned about your child's development, you can access your state's early intervention system. Early intervention services are mandated by Part C of the Individuals with Disabilities Education Act (IDEA). Early intervention describes the array of services that are available to babies and young children (0-3 years old) with

[31] Ibid.

[32] Progeny Health. (2023). *Best practices for management of infants with Neonatal Opioid Withdrawal Syndrome.* https://www.progenyhealth.com/wp-content/uploads/ProgenyHealth_ClinicalGuidelines_NeonatalWithdrawal_11.17.23.pdf

[33] Strabismus is a condition where one eye is turned in a different direction from the other eye.

"…sensitive, non-intrusive parenting and engagement in Early Childhood Education (ECE) can help to buffer these children against early language difficulties."

developmental delays and disabilities and their families. Examples of services your child can receive through early intervention include speech therapy, physical therapy, assistive technology, and nutrition services. You can find your state's early intervention contact information here (many states refer to this process as Child Find). For a step-by-step introduction to early intervention, visit the Center for Parent Information & Resources overview.

"…there is enormous opportunity to ameliorate the consequences of prenatal drug exposure on both the parent and child, with general principles of harm minimization, attention to general health care and a supportive and enriched environment that takes advantage of the benefits of neuroplasticity."[34]

Special education

When your child turns three, they are no longer eligible for early intervention and instead transition to Part B services, which provide services after Part C and until children are 21. While early intervention services are primarily family-focused, the school becomes more central when children begin to be served by Part B. For early intervention, services are guided by an Individualized Family Service Plan (IFSP); the guiding document once the child turns three is an Individualized Education Program (IEP). See this resource for an overview comparing Part B and Part C.

Interdisciplinary services

Louw stresses that, "NOWS requires an interprofessional approach to gain insight from a variety of disciplines regarding the development of infants with NOWS and children prenatally exposed to opioids, and how their lives develop in the context of family and community."[35] As you and your family access early intervention and special education services, you may come into contact with a range of professionals, including speech-language pathologists, occupational therapists, and physical therapists. It can be helpful to become familiar with the range of available services in your area, so that you are prepared should you need them.

Parent resources

As you are looking for information and services to best support your child, remember that there are almost 100 Parent Training and Information Centers (PTIs) and Community Parent Resource Centers (CPRCs) in the United States. These are designed and funded specifically to work with families who have children with special needs. You can find your state's Parent Center here.

---

[34] Oei, J. L. (2024). Improving neurological and mental health outcomes for children with prenatal drug exposure. *Seminars in Fetal & Neonatal Medicine*, *29*(4) https://doi.org/10.1016/j.siny.2024.101557

[35] Louw, B. (2024). Introduction to Neonatal Opioid Withdrawal Syndrome (NOWS). In B. Louw (Ed.), *Neonatal Opioid Withdrawal Syndrome: Speech-language pathologists and interprofessional care* (1st ed.). Routledge. https://doi.org/10.4324/9781003397267

Home environment

You can also make an important and profound difference with the activities you do with your child. Kim and colleagues found that, at age 4.5 years, children who had been exposed to opioids had poorer receptive and expressive language skills than their peers.[36] However, they found that the presence of sensitive parenting, a stimulating home environment, and high-quality early care and education could greatly reduce that disadvantage. "Importantly, the results show that sensitive, non-intrusive parenting and engagement in Early Childhood Education (ECE) can help to buffer these children against early language difficulties."[37]

Conclusion

There are certainly many unknowns in raising a child who has been exposed to opioids prenatally. This can be compounded by the unknowns that can accompany adoption. However, a fundamental awareness of the issue and openness to the challenges it may present can put parents at a huge advantage. Seeking out adoption-competent professionals who will work with your child and your family's unique needs can be an essential part of the journey. Keeping a close eye on your child's development and possible extra needs, as well as being open to accessing services and supports, puts you in a position of strength for best supporting your child and your family.

[36] Kim, H. M., Bone, R. M., McNeill, B., Lee, S. J., Gillon, G., & Woodward, L. J. (2021). Preschool language development of children born to women with an opioid use disorder. *Children*, *8*(4), 268. https://doi.org/10.3390/children8040268

[37] Ibid.

Prenatal Drug Exposure and Adoption

BY ELISA ROSMAN, PhD, MA

About Elisa Rosman

Elisa has spent nearly two decades working as a consultant on issues around early care, education, and adoption. She has worked on a variety of projects, including grant writing, performing evaluation project management, advising on a replication of an Early Head Start model, and writing adoption-related articles.

Elisa has a particular interest in translating research and information to make it most useful for families and practice. Elisa currently serves as the Evaluation Consultant for Formed Families Forward, a nonprofit dedicated to supporting foster, kinship, and adoptive families of children and youth with disabilities and other special needs in Northern Virginia.

She earned her MA in infant and early childhood special education from George Washington University and her PhD in Community Psychology from New York University. She is mom to 4, including 3 children adopted from China.

Originally published in 2025 by National Council For Adoption. Reprinting or republishing without express written permission is prohibited. The Adoption Advocate is edited by Nicole Davi, Emily Kwiatkowski, and Jessica Read. To inquire about guest author opportunities, please contact the NCFA education team at ncfa@adoptioncouncil.org.

NCFA

National Council For Adoption
431 North Lee Street
Alexandria, Virginia 22314

adoptioncouncil.org/adoption-advocate
ncfa@adoptioncouncil.org
(703) 299-6633