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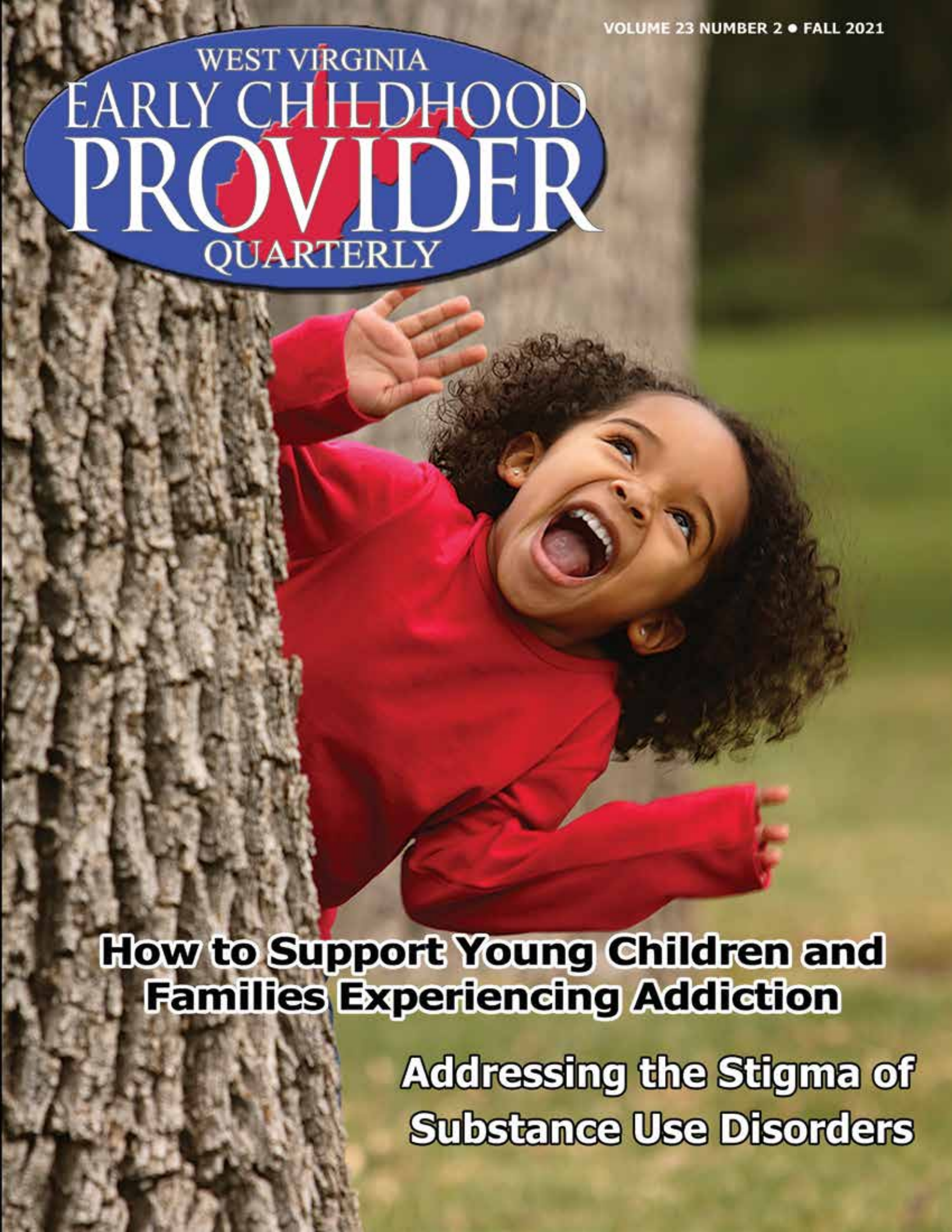
WEST VIRGINIA EARLY CHILDHOOD PROVIDER QUARTERLY



How to Support Young Children and Families Experiencing Addiction

Addressing the Stigma of Substance Use Disorders

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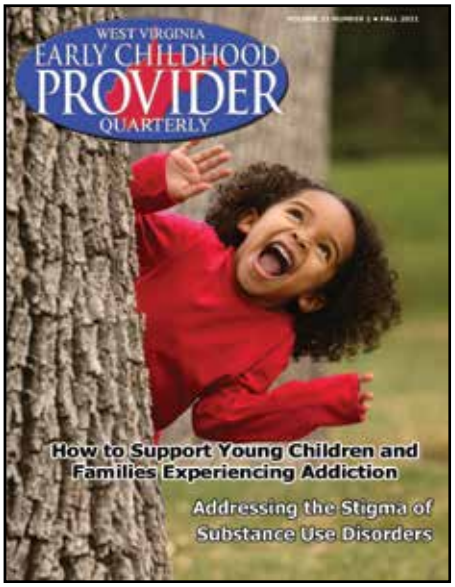

What Are We Doing to Help Children Impacted by the Opioid Crisis?

Submitted by Cindy Chamberlin, MPST, WV Birth to Three, WV Chapter President of To the Moon and Back

Currently one in five children are born substance exposed in the state of West Virginia.

For years, I have been watching our system try to get a handle on the drug crisis and how it impacts West Virginia families. It has only been in the last 3 years that leaders and policy makers are finally starting to talk about the children born with Neonatal Abstinence Syndrome (NAS) or substance exposed in utero. To date, it seems that we are still focusing resources and funding on the parent, their diagnoses and supporting them, as well as working on keeping the family unit together. But we are failing to acknowledge a critical part of this family and assure resources and support for them as well: the baby born substance exposed. These families have at least two members with a diagnosis that require support and ongoing care: a parent working in active substance use disorder or recovery AND a child born substance exposed and/or diagnosed with NAS. We need to be assuring there are wrap around services for both family members and we need a safety plan for if relapse happens.

Some of these children are very difficult to soothe/calm and yet we assume that these parents have the tools they need to succeed instead of educating and empowering them to confidently care for and parent their child. Over the last 15+ years, I have been focused on helping the infant with substance exposure and why we must recognize that these children can and do have challenges beyond their discharge home from the hospital/NICU. At the root of so many issues is stigma; how we treat these mothers and what we call these infants. Babies are NOT addicted (psychologically they cannot be drug seeking in the womb or the NICU); they are born substance exposed or have been diagnosed with NAS where they need medical intervention and/or medication to safely wean off the drugs they were exposed to in utero and are withdrawing from. When we shame and stigmatize babies and families, we are limiting their potential and willingness to be open on how to care for their child.

Over the last ten years, I have tried to learn about and understand Substance Use Disorder (SUD). If I do not make a connection with the mother, caregiver, or foster parent, they are never going to let me consistently work with their infant. I learned a long time ago that if I check my biases at the door and treat the parent the way I would want to be treated, I get so much further and am usually invited to come back for

future visits. I think it is important that we look at our own ideals, values, and understanding and realize that not everyone is cut out to put their biases aside. If that is you, then you are being the bigger professional and giving this family access to care by saying you may not be the provider for them! I have yet to meet a parent that doesn't love and want what's best for their child.

In the last 2 years, researchers are finally starting to look at trends and studying how different drugs impact a developing fetus. While the jury is still out on long term impacts of drugs (both legal and illicit/prescribed and unprescribed), what this article is going to focus on is what WE CAN DO to help these children and families while that data continues to be collected. I think that we can all agree what has happened in the past isn't working: ignoring the issues or assuming everything is fine once a baby leaves the NICU. The reason that resources are finally starting to come to the children is because teachers (who were already in crisis) now have multiple substance exposed children in their classrooms, and they don't typically have extra resources, staffing, or supports (because these children are not qualifying for IEP services in our current system). Our teaching staff has been crying for help. Add COVID and all the stresses that come with it, and it seems we have a perfect storm for disaster OR an opportunity to make systemic changes.

I have been a physical therapist for 29 years and have worked in early intervention for 18 years, the school system for 12, and before that I implemented the developmental care program at the NICU at Raleigh General Hospital in 2000-2003, when we first started to see babies born and diagnosed with NAS. For years, I have been advocating for these children. While each child is different and unique, I have seen similarities in NAS development. These are NOT bad children, they are different. We need to celebrate their strengths and help support their challenges. When we think of other diagnoses, we do not continue to try and cram the square peg into the round hole, so why are we doing it with these children? Why are we not supporting these families to get them the help they need?

Understanding NAS children, from the beginning

During the 3rd trimester as a baby approaches delivery, there is less room in the womb. They push or kick out, hitting mom's abdominal wall and rebound back into flexion: this is called physiologic flexion. When a premature, medically fragile, or NAS baby is born and has to go into the NICU, gravity starts to act on their muscles, making it hard for them to come into a midline flexed position to self soothe. For the NAS infant, arching accomplishes several things: it gives them the feedback of where they are in space, opens their airway, and gives their stomachs more room. Once the NAS child is being medically managed, we start to work on midline motor control and flexion to teach self-calming skills. It is amazing what habits can develop in the early days out of survival and how long it can take to change them.

When we think about transitioning to home an infant diagnosed with NAS, they are leaving a very calm quiet controlled environment. Typically an infant is discharged home after 24 hours of being medication free, so their nervous system is still adjusting. Also, think about what most families do when a child comes home: they celebrate and share their baby with family and friends where, without proper training, overstimulation can occur. Examples of overstimulation/stress cues are:

- Jaw jitters (like if someone is cold),
- Jittery movements,
- Hiccups, not during feeding time,
- Sneezes (repetitive),
- Finger splaying (hand over face with fingers splayed, sometimes called a hand salute),
- Arching/stiffening up,
- Excessive crying.

Of course, if these cues are not recognized then ultimately the baby may go into shut down or sleep ex-

cessively. An irritable baby is a sign that they may be colicky or overstimulated. Equally concerning is a baby that sleeps all the time and a caregiver reports that they have to wake the baby up to eat on a regular basis (especially if they were born and diagnosed with NAS). We need to be teaching families to recognize the stress cues and to adjust their environments accordingly.

The following are strategies to help limit stimulation:

- Lighting: pull blinds/turn off lights
- Sound: turn down/off TV, lower voice when talking, limit electronics, limit to one sound
- Activities: limit visitors, number of people talking/moving in room, etc.
- Can help sooth: rocking (Side to side motion) gentle joint compression through spine
- Firm touch versus light touch
- Firmer pat versus a light tap or rub

Bonding and Development

Marketing has led society to believe that it is "what you buy" and "how much you spend" that impacts development. It is never about the toy. It is always how the caregiver uses the toy to interact and play with the baby.

Babies need an hour of tummy time collectively throughout the day starting on the day they are born! Of course, chest to chest time with the caregiver counts in these early days! It also fosters positive bonding which is the single, most important aspect of early development!

Newborns have a neck righting reaction that helps them lift their head and turn it while on their bellies during their first 2 weeks of life. When babies are placed on their bellies early with that reaction, they get used to and strengthen neck muscles so they can also do it when the reflex has integrated.

We know that through positive bonding with a caregiver, we can double a baby's brain size over the first 2 years of life! As a physical therapist, I am fascinated about how the brain lays down neural pathways for development, so of course the bigger the brain, the more future potential.

There was a study in 2019 (Neonatal Head Circumference in Newborns with Neonatal Abstinence Syndrome, Pediatrics January 2019) that suggested that chronic opioid use during pregnancy sufficient to cause NAS was associated with smaller Head Circumferences (HC) at birth. This study also went on to reveal that 87 percent of participants were mothers on Medical Assisted Treatment (MAT), which is currently the recommended treatment option during pregnancy. The study indicated that 30.1 percent of the NAS infants, had an HC less than or equal to the 10th percentile

and 8.2 percent had a HC less than or equal to the third percentile. This study didn't tell me anything I didn't already know. For years, pediatricians had been sending substance exposed children to the neurologist for smaller head sizes without any real findings or issues arising from those evaluations.

If NAS children are at risk of having a smaller head then positive bonding with their caregivers is critical for these infants, and it is my job to educate and empower families. We can't undo the drug exposure that happened in utero, but we can work on bonding and focus on typical development. When I started talking with these families, like I do my other medically fragile patients, and explain the "why" behind what we are working on, what a difference I saw with follow through. As with most of my families, when expectations are set and they understand why we are working on something, the majority of the time the family not only meets but exceeds those expectations. This is a win for the infant's development and for the caregiver!

Magic Happens on the Floor!

Starting at three months of age, tummy time recommendations increase to 3 hours a day (collectively) and should be done on a firm surface. The bed, pack-n-play, or couch do not give enough support for the baby to start developing proprioceptive and tactile input. For those children being raised by older caregivers and/or grandparents who can't get down on the floor comfortably, the dining room table may be a great place to practice as long as there is direct and constant supervision. It also allows the caregiver to make eye contact and engage with the infant while in this position, which generally increases the baby's tolerance to tummy time. Developmental charts and the emphasis of tummy time has been lost over the years and most first-time parents do not start to think about it until the developmental chart says the child should be rolling. Tummy time and crawling are hard work and critical in development for ALL children, but that doesn't mean it can't be fun! Our NAS infants know all about arching and stiffing up to calm down, but not necessarily how to self soothe in a flexed midline position. It is also important for families to understand why we want to discourage utilizing extension to assist with self-calming.

Next Step: Crawl!

Developmental charts show the emphasis of early motor development is on a baby's belly and on the floor. This helps families understand why core/tummy strength is so important. As an infant develops and begins to master tummy time and has good head control in supported sitting, often jumperoos, exersaucers, and walkers are introduced. The American Academy of Pediatrics does not recommend walkers. Walkers encourage extension or thrusting of the trunk. Typically, NAS infants placed in a walker master moving them backwards pushing into extensor thrust and then they will get their bellies up on the tray in front of them, go up on their toes to learn how to move it forward. What this position does NOT do is engage the

stomach/core muscles which are needed to walk independently. Floor and tummy time is best; however, I also realize that parents need a safe place to put a child when they are doing things and know they will be safe. An exersaucer or jumperoo will accomplish that, a walker will not. Research says that babies should crawl for 4.5 months before they start walking, but caregivers always want to know when the baby is going to walk. As a physical therapist, I know most children are going to walk. I want the child born substance exposed to crawl--to develop their tactile, vestibular, and proprioceptive systems and strengthen their core! Crawling also helps develop the arches in the hand and works on scapular stability, which impacts hand writing and ball throwing skills. All of this work will help them as they get older, as well as set them up to work on higher level balance skills (i.e. climbing stairs, jumping, hopping, skipping) instead of the child who is always chasing their balance and core strength. You have to have stability before you can have mobility.

On the Move!

If you didn't already know, NAS infants are movers and at times it may seem like they only have one speed: fast. Once they start it is difficult to get them to slow down, especially if core strength is an issue. I have found it is much easier to work on the foundational skills (core strength) early on than it is to try and get a child who is already moving to slow down. Quality of movement is more important than the quantity of movement. This is when I encourage sit-to-stand activities leaning forward ("nose over toes") versus arching or pushing back against something to get to a standing position. Often children born substance exposed/with NAS appear like "bulls in a china shop", but is that because their vestibular and proprioceptive systems are under developed, or is it something else? When I get families to focus on tummy time and crawling to develop the sensory systems and work on core strength, a child may still be motivated to move, but they have more organized sensory systems and better quality movements. As a side note, this is often when I talk to caregivers about pain tolerance. NAS infants can have an impaired pain response (both hypo or hyper). I mention it so if they fall/bump into something and it looks like it hurts, check them. Some children may not be responding appropriately and it is something caregivers need to be aware of.

Never Too Late

Throughout this article I have talked about early development and core strengthening. People ask me, "What if my child skipped that stage?" It is never too late to do tummy time or incorporate weight bearing through hands in a classroom or gym: scooter boards, crab and bear walking, wall push ups, and wheel barrel racing are all activities that help work on that core strengthening and can be incorporated into class activities. Alternative seating in preschool and classrooms can help (therapy ball, therapy peanut, move-n-sit) as well as allowing them to get up and move.

Impacts of Trauma

What I haven't touched on, but is equally as important, are the impacts of trauma. We know that children born with NAS are more sensitive to stress and trauma (some studies say up to twice as sensitive). What some people see as stubbornness, oppositional behavior, or acting out, I see as resilience. I try to remember that sometimes that behavior is what has helped them survive up until this point (this is not always easy but again, we must remember we are working with developing children who have endless potential). How can we use that resilience and help them accomplish their goals? I am a firm believer there are NO bad children, only bad circumstances. We are so quick to judge through the eyes of an adult that we forget that these children's nervous systems are still growing and developing, and they are "reacting". We should not be judging them based on adult expectations. I also believe that knowing what to expect through structure

and routines can help alleviate stress.

Moving to School

As children transition to school, there are more rules, more structure, and expectations. Generally when a child is at home, it's a "child driven" world. They play and explore but it is often on their time frame and in the way they enjoy (some homes have more structure and stability than others). When a child transitions to school, there are many things that can be exciting and possibly overwhelming: a new teacher, classmates, room to explore, different toys, etc. Sometimes that "child driven" world struggles to embrace the"adult driven world" of school (i.e. classroom routines, lines, circle time, scheduled play, etc). This is also a time where the NAS child may experience challenges with adapting to structure and routine as they transition to school. Often children's emotional regulation and endurance develops during these early school years and seems to fall into place about the 2nd or 3rd grade.

Last year, I sat in a conference and learned about the Learning Hierarchy. It put all my ramblings about organizing sensory systems into perspective. Like Maslow's hierarchy, you have to have the bottom tiers of the pyramid organized and secure before you can move up. What blew me away about this is teachers learn how to teach cognitive skills (which is the top of the pyramid), but are not necessarily given the tools of setting their students up to get ready to learn. The Learning Hierarchy emphasized the importance of collaboration between the therapy and teaching professions to help all children succeed! It also confirmed what I have known for years, children who have core strength and organized sensory systems have an easier time getting ready to learn.

As we continue to learn more about children impacted by substance exposure, families surviving with substance use disorders, and how we can all make a positive impact let's not forget to work on the things that we already know:

- Positive bonding can double a brain size in the first 2 years of life.
- You must have stability before you can have mobility.
- Tummy time helps develop our visual, vestibular, proprioceptive, and tactile systems.
- All children and families have dreams and potential.

To The Moon And Back is a nonprofit dedicated to providing support and education to the families and professionals working with children born with NAS and substance exposure

Do you know a child who is not *moving *hearing *seeing * learning or *talking like others their age?

By **3** months,
Does your baby…
- grasp rattle or finger?
- hold up his/her head well?
- make cooing sounds?
- smile when talked to?

By **6** months,
Does your baby…
- play with own hands/feet?
- roll over?
- turn his/her head towards sound?
- holds head up/looks around without support?

By **9** months,
Does your baby…
- sit alone or with minimal support?
- pick up small objects with thumb and fingers?
- move toy from hand to hand?

By **12** months,
Does your baby…
- wave goodbye?
- play with toys in different ways?
- feed self with finger foods?
- begin to pull up and stand?
- begin to take steps?

By **18** months,
Does your baby…
- cling to caretaker in new situations?
- try to talk and repeat words?
- walk without support?

By **24** months,
Does your baby...
- point to body parts?
- walk, run, climb without help?
- get along with other children?
- use 2 or 3 word sentences?

If you are concerned about your child's development, get help early.

Every child deserves a great start.

WV Birth to Three supports families to help their children grow and learn.

To learn more about the WV Birth to Three services in your area, please call:

1-866-321-4728

Or visit www.wvdhhr.org/birth23

West Virginia Birth to Three Growing Together

WV Birth to Three services and supports are provided under Part C of the Individuals with Disabilities Education Act (IDEA) and administered through the West Virginia Department of Health and Human Resources, Office of Maternal, Child and Family Health.

How to Support Young Children and Families Experiencing Addiction

Submitted by Tina Ramirez, Director, Great Rivers Regional System for Addiction Care, Division of Addiction Sciences in the Department of Family and Community Health

Every family is unique, but all families share a bond that can be used to support one another during trying times. While there is no one-size-fits-all solution for helping a family member who is drinking too much, using drugs, or dealing with a mental illness, research shows that family support can play a major role in helping a loved one with mental and substance use disorders https://www.samhsa.gov/families. There are many resources within West Virginia that families may find helpful.

Help&HopeWV

Help4WV Resources

Help4WV is available 24 hours a day, 7 days a week to assist in finding the most appropriate and available treatment for an array of youth behavioral health needs, from parenting support to immediate crisis response. Contact 1-844-HELP4WV to talk to a trained Helpline Specialist who can help you understand options and link you directly to treatment providers. https://www.help4wv.com/ccl

Help4WV also has a list of resources pertaining to youth and families on their website that includes: Children Mobile Crisis Response Teams, Youth Outpatient Mental Health Treatment, Pregnant Women Addiction Services, Youth Outpatient Addiction Treatment and Youth Peer Support and Support Groups. https://www.help4wv.com/resources

Did you know that parents and caregivers can influence whether children

use alcohol or drugs? It is crucial that adults start talking with children about alcohol and drugs well before the teen years. The earlier a person starts using drugs or alcohol, the more likely they are to develop substance use disorders. Although you may not think so, parents have a significant influence on teen's decisions.

Ways to help children make good decisions about drugs and alcohol:

1. Establish and maintain good communication with your child.
2. Get involved in your child's life.
3. Make clear rules and enforce them consistently.
4. Be a positive role model.
5. Monitor your child's activities.
6. Teach your child to choose friends wisely.

https://helpandhopewv.org/teens-families.html

Project Hope for Women and Children

Project Hope for Women & Children provides a stable and supportive environment for women and their children so they can work toward long-term recovery, developing healthy parenting skills and building safe family relationships. As a comprehensive treatment facility for women and their children, Project Hope provides onsite peer and residential support, life skills training, and mental health services. Our individual approach to treatment also includes educational support services, career development, nutrition, exercise support, parenting and relationship courses, spiritual care and financial education. https://www.marshallhealth.org/projecthope

Prestera Renaissance Programs

Prestera's Renaissance Programs are long-term residential addiction treatment programs for women and their dependent children and are offered in both Huntington and Charleston. Renaissance brings women and women with children together to support them in their life of recovery. Long-term residential addictions recovery services can last three months, six months, one year or longer. Family relationships are emphasized. Long-term residential addictions recovery services are also available to women without children. https://www.prestera.org/services/addictions-recovery/#heading1

The Parent Project® – A Training Program for Parents

The Regional Youth Service Center Region 5 (a program of Prestera) is excited to introduce a new free program for parents. The Parent Project® is a parent centered educational group for those raising difficult or out-of-control children. The Parent Project® is both an intervention and prevention program. "The manual the hospital forgot to give you." https://www.facebook.com/RYSCWV5/

WV Birth to Three

WV Birth to Three is a statewide system of services and supports for children under age three who have a delay in their development, or may be at risk of having a delay, and their family. WV Birth to Three (Department of Health and Human Resources, through the Bureau for Public Health and the Office of Maternal, Child and Family Health), is the lead agency for Part C of the Individuals with Disabilities Education Act (IDEA) and assures that family centered, community based services are available to all eligible children and families at no cost. http://www.wvdhhr.org/birth23/

Right from the Start

Right From The Start (RFTS) is a statewide program that helps West Virginia mothers and their babies lead healthier lives by offering home visitation services with a Designated Care Coordinator (registered nurse or licensed social worker). https://www.wvdhhr.org/rfts/

Treatment and Recovery Programs for Substance Use Disorder as well as Youth Services and Veterans Resources:

West Virginia Perinatal Partnership

The Drug Free Moms and Babies (DFMB) Project is a comprehensive and integrative medical and behavioral health program for pregnant and postpartum women. The project supports healthy baby outcomes by providing prevention, early intervention, addiction treatment, and recovery support services. https://www.wvperinatal.org/initiatives/substance-use-during-pregnancy/drug-free-moms-and-babies-project/

Maternal Opioid Model (MOMS) The Drug Free Moms and Babies program (developed in 2011 by the West Virginia Perinatal Partnership with

funding from DHHR's Office of Maternal, Child and Family Health, and the Claude Worthington Benedum Foundation) is a comprehensive and integrated medical and behavioral health program for pregnant and postpartum women. The project supports healthy mother and baby outcomes by providing prevention, substance use screening, early intervention, substance use disorder treatment and recovery support services. Currently there are 17 sites statewide which offer this program.

Services for Families Affected by Substance Use Disorder:

River Valley CARES (Center for Addiction, Research, Education and Support)

RV CARES, located in Huntington's West End, is providing tailored care not only to children ages 6 weeks to 2 years who have been exposed to substance use disorder (SUD), but also to their families. This unique center is designed to provide high quality and comprehensive services not only to children recovering from neonatal abstinence syndrome (NAS) but any child who has had their young life affected in some way by substance use disorder. https://healthyconnectionswv.org/Programs/RV-CARES.aspx

KIDS Clinic is a branch of Healthy Connections that brings together medical and behavioral specialists from different organizations to care for children and their families, including those affected by substance use disorder. The mission is to help children build healthy brains and bodies through healthy relationships early in their lives.

Caregivers partner with professionals as a team and are dedicated to understanding the unique needs of each child and building the best possible plan to address those needs. https://healthyconnectionswv.org/Programs/KIDS-Clinic.aspx

Minnie Hamilton Health System

This behavioral health team works with ages 3 and up on a variety of topics. These life hurdles may include but are not limited to: anxiety, depression, bi-polar/mood alterations, grief, aggression/anger, self-esteem, stress, PTSD, marital strife, premarital, repercussions of divorce or separation, irritability, acting out behaviors in children, school issues, ADHD, parenting solutions, substance use, and medicated assisted treatment.

The team consists of Licensed Professional Counselors, a Licensed Social Worker, a Case Manager, and a Psychosocial Program Coordinator. Services are provided in Calhoun County at the Annex building of the hospital located in Grantsville, as well as at Pleasant Hill Elementary, Arnoldsburg Elementary, and Calhoun Middle & High School. In Gilmer County, services are provided at Gilmer Elementary and Gilmer Middle and High School. Patients can be outpatient as well as MAT services at the Glenville clinic, located at the Waco Center. Additionally, SMART Recovery groups are on Wednesday evenings from 5-6:30 p.m. at the Glenville Clinic.

Health Center Services - Minnie Hamilton Health System (mhhs.healthcare)

United Summit Center

United Summit Center (USC) is a comprehensive mental health center servicing six counties in north central West Virginia. United Summit Center and Chestnut Ridge Center, in coordination with WVU Medicine, work together to provide quality behavioral health services to people who have acute and chronic psychiatric disabilities, intellectual/developmental disabilities, substance abuse problems, and to people who are in crisis in an effort to assist in the achievement of their fullest potential.

1-800-SUMMIT-0 Adult Crisis Line

1-844-985-4371 Child Crisis Line

304-623-5661 Main Office

Services at the United Summit Center include Individual Therapy (adult and child outpatient), Family Therapy, Group Therapy, case management, outreach, psychiatric evaluations and medication management, school based counseling, and Crisis Stabilization Residential Unit. United Summit Center | WVU Rockefeller Neuroscience Institute (wvumedicine.org)

West Virginia Data Resources

West Virginia KIDS COUNT

West Virginia KIDS COUNT

West Virginia KIDS COUNT provides the most trusted data about the well-being of children and builds alliances to advocate for what children need. https://wvkidscount.org/

Partnership to End Addiction

Partnership to End Addiction

Partnership to End Addiction https://drugfree.org/parent-e-books-guides/

2-1-1 West Virginia

United Way

West Virginia 211

West Virginia 211 keeps an accurate and comprehensive database that peo-

ple can use to find health and human services. The database allows people to browse hundreds of health and human services online, learn about specific programs, intake requirements, eligibility, operation hours and more. The database also has information on disaster related services. https://wv211.org/

Signs of how to recognize a child/ family that may be dealing with addiction

National Institute on Drug Abuse

The National Institute on Drug Abuse states that some signs of risk can be seen as early as infancy or early childhood, such as aggressive behavior, lack of self-control, or difficult temperament. As the child gets older, interactions with family, at school, and within the community can affect that child's risk for later drug abuse. https://www.drugabuse.gov/publications/preventing-drug-use-among-children-adolescents/chapter-1-risk-factors-protective-factors/what-are-early-signs-

Nationwide Children's Hospital

Here are some of the warning signs of addiction in a child or adolescent according to Nationwide Children's Hospital:

- The odor of alcohol or tobacco or other odd odors on the breath or skin.
- A change in behavior, becoming more argumentative or isolating themselves.
- Spending more than 20 hours a week on the Internet or playing

video games.

- Red eyes and chronic health complaints (flu-like aches and pains, upset stomach).
- Changes in eating or sleeping patterns.
- Loss of interest in school.
- A drop in grades.
- Skipping classes.
- New friends (with little interest in families or school activities).
- Chemical-soaked rags or papers.
- Paint or other stains on clothing, hands or faces.
- Feelings of loneliness.
- Depression
- Harmful or risky behaviors (such as breaking things, vandalism, stealing).
- Hurting themselves (cutting their bodies).
- Compulsive behaviors.
- Eating disorders.

https://www.nationwidechildrens.org/conditions/addiction

West Virginia Quick Response Teams

There are 35 Quick Response Teams (QRTs) throughout the state. These teams visit clients within 72 hours after an overdose. They work with the whole family, including the children, to link them to services in the community such as treatment, food, housing and employment. The QRTs visit the families every week to establish relationships and build trust with the hope of helping them become productive members of society.

"One of the things we do as a QRT is spend one-on-one time with the kids we visit. They crave the attention and it gives the other team members a chance to talk with the parent who is struggling, JD"

"It's very obvious to me that the kids are screaming for some security. We

advise the parents to listen to their kids and not just shut them down, EC."

"The kids that we meet have all of their basic physical needs met. It's the emotional needs that are lacking and it's very obvious, AF."

Anyone can reach out to the QRTs and schedule a visit. Clients experiencing substance use disorder to do not need to have overdosed to have the team come out. https://www.marshallhealth.org/services/addiction-medicine/great-rivers-regional-system-for-addiction-care/

Helping families experiencing addiction can be challenge. This collection of West Virginia resources may be a good place to start.

Contact Tina Ramirez, ramirezt@marshall.edu (304) 691-6858 for more information on any of the information listed.

Why Should WV Child Care Professionals Consider Infant Mental Health Endorsement?

Myth: Endorsement is only for those who have lots of degrees and experience.

FACT: Neuroscience tells us that the first three years of life are critical to lifelong health and well-being, making the role and responsibilities of home visiting professionals incredibly important to family and community success. The IMH Endorsement® recognizes professionals who work with or on behalf of infants, toddlers, and their families. It's the largest and most recognized IMH credentialing system in the United States, and it's available to you here in West Virginia! Anyone in the early childhood field can work toward earning Endorsement, including directors, supervisors, child care professionals, and service coordinators.

Why should I pursue Endorsement?

Good for You: Earning IMH-E® enhances your credibility and confidence in working with or on behalf of infants, toddlers, and their families. You'll gain recognition and belong to a cross-systems, multi-disciplinary network of Endorsed professionals in WV.

Good for Babies and Families: Infants, toddlers, and families receive culturally sensitive, relationship-based early childhood services provided by a workforce that demonstrates a common set of core competencies.

Good for Communities: IMH-E® provides assurance to families that early childhood professionals meet high standards of care and are prepared to support optimal development of infants, young children, and their families.

Good for Programs: IMH-E® professionalizes the early childhood field and ensures consistency of professional standards across programs, no matter the curriculum, location, or services.

The IMH Competencies® naturally align with Early Childhood work

IMH-Endorsement® supports the belief that positive social-emotional development is foundational to other learning, and that healthy development happens within the context of nurturing relationships and environments.

IMH competencies® provide a professional development "road map" for acquiring the knowledge and skills needed to attend to the often complex nature of early social and emotional development and parent-child relationships.

Financial assistance is available for Endorsement. Local Child Care Resource and Referral agencies have funds available to provide financial assistance for those seeking Endorsement within the Early Childhood field.

For more information, please contact the West Virginia Infant/Toddler Mental Health Association or visit www.nurturingwvbabies.org

Special thanks to the Wisconsin Alliance for Infant Mental Health for sharing information

Caregivers Coping with Mental Health Problems, Substance Abuse, and Trauma

Struggling families appear every day in clinics, childcare agencies, churches, schools, and domestic violence shelters. Many more families never even reach these points of entry for help. They find themselves isolated and trying to cope on their own. Besides the difficult task of raising children—often while working full-time—many caregivers deal with added stressors such as mental health problems, substance abuse, and a history of trauma. These problems can challenge a parent's ability to be attentive to his or her children. Some very young children in these situations may have experienced or witnessed traumatic events. Sometimes their parents are unable to protect them from physical or psychological harm. For a small group of these children, parents or other caregivers cause the harm (Center on the Developing Child at Harvard University, 2007). These experiences can affect infants and toddlers in profound ways.

There are a number of ways that policymakers and practitioners can intervene to improve outcomes.

Life stressors, such as physical or sexual abuse, exposure to domestic violence within the family, witnessing community violence, and depending on parents with mental health and substance abuse problems often place the children in these families on a difficult path. These problems also tend to cluster in families: Often, if one is present, others are present as well (Knitzer and Lefkowitz, 2006). We also know that the more of these harmful experiences a child is exposed to, the more likely the child will have difficulty with social and emotional functioning in childhood, exhibit cognitive problems, fail in school, and have high levels of mental health problems and substance abuse as an adult (National Scientific Council on the Developing Child, 2004b; Gewirtz & Edelson, 2004; Heather, Finkelhor, & Ormond, 2006). Chronic health conditions (including heart disease, diabetes, cancer, and lung disease) have also been linked to adverse experiences in childhood (Felitti et al., 1998).

Experiences Affect the Young Child's Brain

Studies looking at how the brain develops in infants and toddlers (National Scientific Council on the Developing Child, 2004b, 2005) give us a better understanding of why this early exposure to very stressful situations can lead to such harmful outcomes. During the earliest years—from prenatal to age 5 years or so—the brain is most open to outside influences. Because the brain is shaped in important ways by experiences at this early age, overly stressful or traumatic experiences—such as witnessing or experiencing violence, or being raised by caregivers affected by substance abuse or mental health problems—can have a powerful impact on the young brain. These adverse experiences can even affect the basic foundation of the developing brain, contributing to problems throughout life.

But that is only half the story. Infants and toddlers are also ripe to soak up the beneficial aspects of their daily life. The young child's immediate environment—the interactions with responsive parents and other caregivers, rich sensory stimulation, and routines that shape a child's day—can actually build the brain in healthy ways.

The articles on pages 21-23 are reprinted from Supporting Infants,Toddlers, and Families Impacted by Caregiver Mental Health Problems, Substance Abuse, and Trauma, A Community Action Guide. DHHS Publication No. SMA-12-4726. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2012.

Protective Factors: Helping to Build Resilience

Although all families with young children need the support of the larger community, support from a responsive community is even more critical for vulnerable children and families. A literature review conducted by the Center for the Study of Social Policy identified five major protective factors (Knitzer & Lefkowitz, 2006) shown to lead to better outcomes for children, even when life has been unkind to them:

1. Concrete support in time of need;
2. The presence of a good support system;
3. The use of good parenting skills;
4. The mental health and psychological resilience of the parents or other caregivers; and
5. The child's own social-emotional and cognitive capabilities.

When present in families, these factors can make the stressful times more manageable or can help prevent some stressful situations in the first place. A responsive community can influence ***all*** of these five protective factors.

Creating these growth-promoting environments for children can be a challenge for any family. For parents or other close caregivers struggling with mental health problems, substance abuse, or trauma, the task can be daunting. Society still tends to blame any individual facing these problems, often judging parents or caregivers even more harshly. Even those of us who work with children and families can forget that many parents were neglected, abused, or traumatized early in life. The effects of these experiences often make it more challenging for these parents to be the kind of caregivers they want to be. For our efforts to be successful, we need to take this information into account when we structure our outreach efforts and programs (Knitzer & Lefkowitz, 2006). It is important to recognize, too, that all families have strengths. Responding to families involves addressing challenges in a supportive way, as well as recognizing and building on strengths.

The importance of focusing on the well-being of infants and toddlers, as well as their parents and other caregivers, is slowly beginning to penetrate public consciousness.

The exciting news is that, as members of a responsive community, there is much we can do to create and maintain these protective factors. The importance of focusing on the well-being of infants and toddlers, as well as their parents and other caregivers, is slowly beginning to penetrate public consciousness. We have an important role in spreading the message—that the earliest years are crucial for the health of the individual and the health of our communities—whenever and wherever we can. Not only will individual children and families benefit, so will society as a whole. Nobel Prize-winning economist James Heckman writes convincingly that investing in our infants and toddlers is the best economic investment we can make (Heckman & Masterov, 2004). In fact, he says that for every year of a child's life we delay in making these investments, we will end up spending more money on problems we could have prevented in the first place—money wasted on lost productivity, incarcerations, mental health and substance abuse treatment, and physical health problems. To be successful in helping children, this investment also needs to target the most powerful influence on a child's well-being: parents and other caregivers.

PRINCIPLES OF A RESPONSIVE COMMUNITY

1. A responsive community works to ***read and interpret the signals*** of stress in children, their parents, and other caregivers. These signals might be very different from family to family depending on the upbringing of the family members, their background culture, and their past experiences with service providers or community groups.

2. A responsive community understands that the ***earlier you respond to these signals, the better the outcome*** will likely be.

3. A responsive community tries to ***prevent stress in families by changing situations*** that are potentially harmful to children, and by thoughtfully creating conditions that support healthy functioning.

4. In a responsive community, providers, policymakers and community members know that ***relationships matter***: A baby or toddler needs a healthy relationship with at least one adult. In the same way, each family needs a network of healthy relationships with family, friends, neighbors, childcare providers, teachers, and other members of the community. Community efforts should focus on building this supportive network.

5. A responsive community sets up resources that ***meet the family where it is*** whenever possible. Coordinated services—with supports for children and their caregivers at one site—make it more likely that a family will be able to access the services they need.

6. A responsive community realizes that ***one size does not fit all.*** Whenever possible, services and supports should be designed to be as flexible as possible to ensure that they address each family's particular needs.

7. A responsive community ***works together and builds partnerships*** to create a thoughtful plan to address the needs of children and their families. Relationships matter—not only for children and caregivers but also for our work with them.

8. Although partnerships and coalitions are useful, being a member of a responsive community also means ***asking yourself first: What can I do?*** In my role as a service provider, advocate, administrator, or law enforcement officer, what can I do to address the needs of the young children and families that I meet? Sometimes a committee is not needed—sometimes all they need is you.

9. A responsive community works with the understanding that family members struggling with mental illness, substance abuse, or trauma have experienced significant stresses throughout their lives and may not always have had necessary supports. Being genuinely cared about, listened to, and responded to can powerfully support a family to make positive changes. ***Little things can make a difference, if they are based on respect.***

10. Often we see families during their most difficult times, but a responsive community recognizes that ***each family has strengths***. Each family's story has within it signs of how they have struggled to meet the challenges that face them. You can help rebuild hope by uncovering and acknowledging these strengths.

Concerned about your CHILD'S DEVELOPMENT?

Help Me Grow, a free developmental referral service, provides vital support for children from birth to age five including:

- Information and community resources to aid development
- Free developmental screening questionnaire
- Coordination with your child's doctor

Talk to a care coordinator and schedule a developmental screening for your child today.

Help Me Grow: 1-800-642-8522
www.dhhr.wv.gov/helpmegrow

Help Me Grow
West Virginia

StigmaFreeWV

Addressing Stigma of Substance Use Disorders

Substance use disorder is a treatable chronic health condition from which people can and do recover. However, many people with substance use disorders do not seek the treatment they need because of the stigma they face. People with substance use disorders may be viewed more negatively than people with other disorders and disabilities - even by their health care providers. **ALL West Virginians can play a role in reducing stigma and encouraging treatment for those who need it.**

STIGMA

A collection of attitudes, beliefs, behaviors, and structures that generate negative attitudes about people with a condition.

WAYS TO REDUCE STIGMA

Change Our Language and Labels

Replace words like "addict" and "junkie" with "person with substance use disorder."

Learn About the Issue

Education reduces stigma. Learn about the science of addiction; mental health and substance use disorders; the science of trauma; and treatment with medication.

Personal Experiences

Positive interactions with people with stigmatized conditions can change attitudes. Invite people to share their story.

Review Practices and Policies

Review workplace and other policies and practices. Support policies that increase access to services, compliance with treatment, and overall health and well-being.

TYPES OF STIGMA

PUBLIC OR SOCIETAL STIGMA is the public's reaction to individuals with a stigmatizing condition such as substance use disorders or other behavioral health issues.

PERSONAL OR SELF STIGMA is the internalization of publicly stigmatized beliefs. Self stigma can result in shame, guilt, reduced sense of hope, social withdrawal and isolation, and a decrease in compliance with treatment.

COURTESY STIGMA is stigma directed toward family and friends of those with a stigmatized condition. Courtesy stigma can isolate family members, lead family members to feel guilty, create a sense of shame, and can make the family member less likely to encourage treatment.

STRUCTURAL STIGMA includes laws, policies, and procedures that limit the opportunities of people with substance use disorder or other behavioral health issues. Structural stigma can be found in businesses, organizations, the courts, government, school systems, and social services.

844 HELP4WV

HELP4WV offers a 24/7 call, chat, and text line that provides immediate help for any West Virginian struggling with an addiction or mental health issue.

1-844-435-7498 www.help4wv.com

This resource is funded through a federal Substance Abuse and Mental Health Services Administration (SAMHSA) grant administered by the West Virginia Department of Health and Human Resources, Bureau for Behavioral Health.

What Can You Do?

StigmaFreeWV

Listen with respect to individuals with behavioral health issues. Listen without judgment. Treat all people with dignity, respect, and compassion.

Speak out against stigma. Speak out online and in person. Consider sharing your story.

Avoid using hurtful labels. Challenge your own assumptions and stereotypes. We all have them.

Promote anti-stigma programs and policies in the workplace and community.

Counter misinformation with evidence-based facts. Learn and share information about substance use disorders with friends, family, and coworkers.

Support harm reduction strategies in your community such as needle exchange programs, naloxone training and distribution, and treatment with medication.

HEALTH CARE PROVIDERS

Many health care providers treat patients with substance use disorders differently and have lower expectations for health outcomes for those patients. Health care providers play an important role to reduce the burden of stigma. Using language that supports pro-health activities, even if a person is actively using substances, can help decrease stigma.

MEDIA

- Report on substance use disorders and treatment in the same way you would other chronic medical conditions such as diabetes or cancer.
- Use person-first language – put the person first, and the disease second – “a person with substance use disorder.” Avoid using stigmatizing terms.
- Share solutions that exist. Many patients fully recover and go on to lead productive lives. Share accounts of how people are responding to effective evidence-based solutions.
- Humanize the condition – use language that humanizes and personalizes the condition and avoid using fear and blame tactics.
- Use reliable sources – identify potential biases in source materials and provide a variety of voices.
- Communicate the many different pathways to recovery.
- Share the long-term view. Substance use disorder is a chronic disease and it can take years to recover.
- Be respectful – many families have experienced the loss of loved ones to substance use disorder. Be respectful in tone.

Source: https://www.psychologytoday.com/blog/addiction-recovery-101/201801/communicating-about-addiction-accuracy-or-alienation

Health & Human Resources BUREAU FOR BEHAVIORAL HEALTH

StigmaFreeWV

For more information, go to: **StigmaFreeWV.org**

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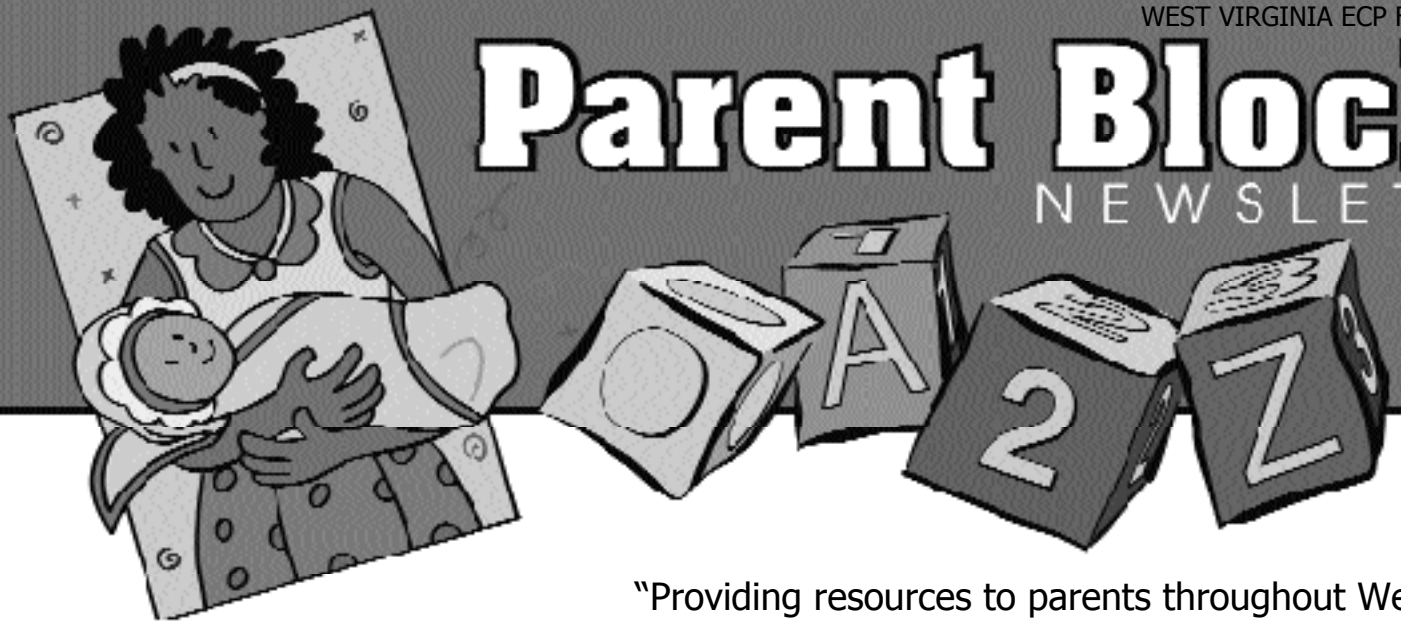


"Providing resources to parents throughout West Virginia"

Volume 18, Issue 1, Fall 2021

Supporting Families Experiencing Addiction

The U.S. opioid epidemic is a multigenerational crisis that has lasting impacts on child development and family stability. In the face of adversity, hope and healing will be found in positive, protective, and supportive relationships. These relationships are the vehicle for repair that can break the cycle of substance use.

Each of us has a shared investment in supporting the brain development of infants and young children, ensuring a foundation that supports a lifetime of learning and productive participation in society. By tending to the needs of a parent/caregiver experiencing substance use, parents can learn and understand how a secure attachment with their children should look and how their own histories of being parented impact their current parenting behaviors. Group participation also builds protective factors by fostering a sense of community, support, and social connectedness.

There are many resources available throughout West Virginia that can help support families experiencing substance use.

West Virginia 211 keeps an accurate and comprehensive database that you can use to find health and human services to meet your needs. The database allows you to browse hundreds of health and human services online, learn about specific programs, intake requirements, eligibility, operation hours and more. https://wv211.org/ or call 844-Help4wv

WV Parent Blocks Newsletter is a project of West Virginia Early Childhood Training Connections and Resources, a collaborative project of West Virginia Department of Health and Human Resources/Bureau for Children and Families/Division of Early Care and Education; WV Head Start State Collaboration Office; Office of Maternal, Child and Family Health/West Virginia Birth to Three; and West Virginia Home Visitation Program and is supported and administered by River Valley Child Development Services.

SUPPORTING A LOVED ONE DEALING WITH MENTAL AND/OR SUBSTANCE USE DISORDERS

STARTING THE CONVERSATION

When a family member is drinking too much, using drugs, or struggling with a mental disorder, your support can be key to getting them the treatment they need. Starting the conversation is the first step to getting help.

How You Can Help

1. **IDENTIFY AN APPROPRIATE TIME AND PLACE.** Consider a private setting with limited distractions, such as at home or on a walk.

2. **EXPRESS CONCERNS AND BE DIRECT.** Ask how they are feeling and describe the reasons for your concern.

3. **ACKNOWLEDGE THEIR FEELINGS AND LISTEN.** Listen openly, actively, and without judgement.

4. **OFFER TO HELP.** Provide reassurance that mental and/or substance use disorders are treatable. Help them locate and connect to treatment services.

5. **BE PATIENT.** Recognize that helping your loved one doesn't happen overnight. Continue reaching out with offers to listen and help.

What to Say

"I've been worried about you. Can we talk? If not, who are you comfortable talking to?"

"I see you're going through something. How can I best support you?"

"I care about you and am here to listen. Do you want to talk about what's been going on?"

"I've noticed you haven't seemed like yourself lately. How can I help?"

For more resources, visit www.SAMHSA.gov/families.

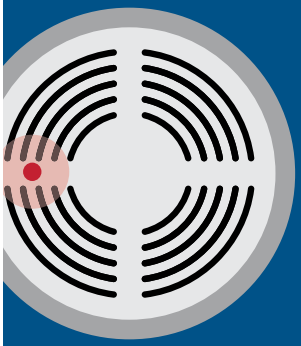
If you or someone you know needs help, call 1-800-662-HELP (4357) for free and confidential information and treatment referral.

Prevent home fires.
Protect what matters.

Young children ages 0 to 4 are at a higher risk of death or injury from a home fire than older children. Some children are curious about fire. They might play with items like lighters, matches, or stovetops.

☐ Protect

Keep children 3 feet away from anything that can get hot. Space heaters and stovetops can cause terrible burns.



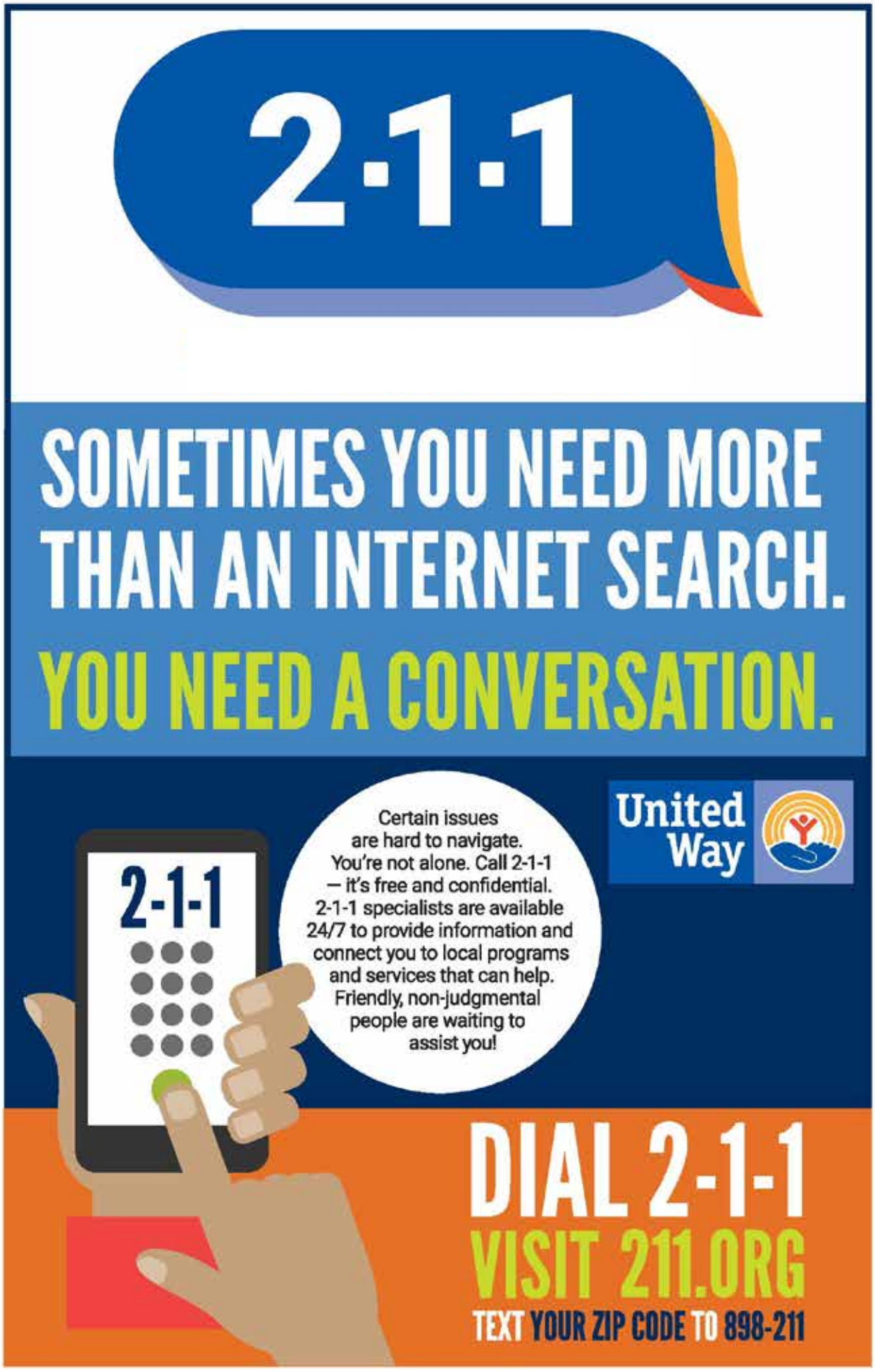
☐ Prepare

Have working smoke alarms on every level of your home. You should also have a smoke alarm inside bedrooms and outside sleeping areas. The sooner you know there is a fire, the more time you have to escape.

☐ Plan

Have a plan for young children. You will need to wake babies and very young children and help them get out. In your plan, talk about who will help each child get out safely.

Learn more about fire prevention: **www.usfa.fema.gov**


2-1-1
SOMETIMES YOU NEED MORE THAN AN INTERNET SEARCH.
YOU NEED A CONVERSATION.
Certain issues are hard to navigate. You're not alone. Call 2-1-1 – it's free and confidential. 2-1-1 specialists are available 24/7 to provide information and connect you to local programs and services that can help. Friendly, non-judgmental people are waiting to assist you!
United Way
2-1-1
DIAL 2-1-1
VISIT 211.ORG
TEXT YOUR ZIP CODE TO 898-211