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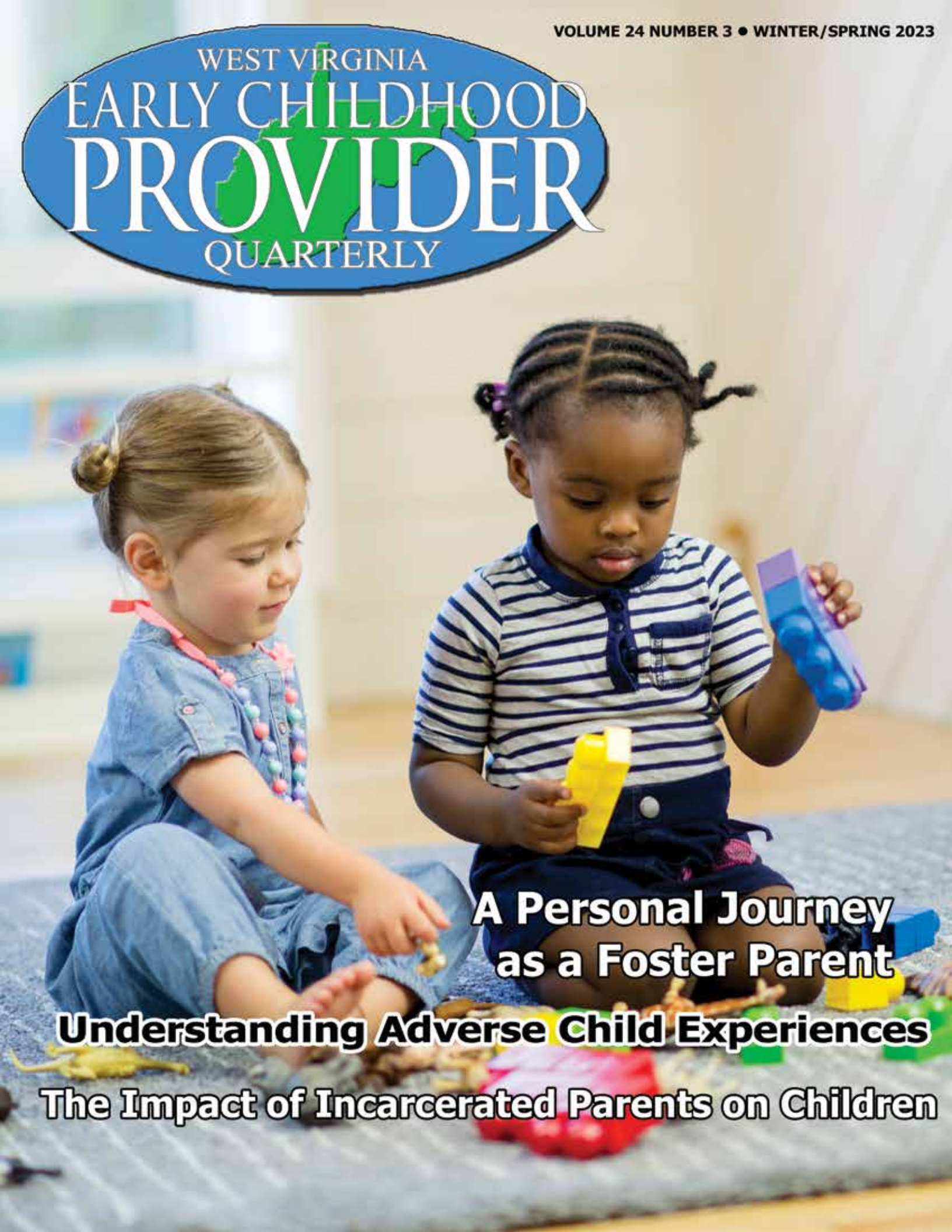
WEST VIRGINIA EARLY CHILDHOOD PROVIDER QUARTERLY



A Personal Journey as a Foster Parent

Understanding Adverse Child Experiences

The Impact of Incarcerated Parents on Children

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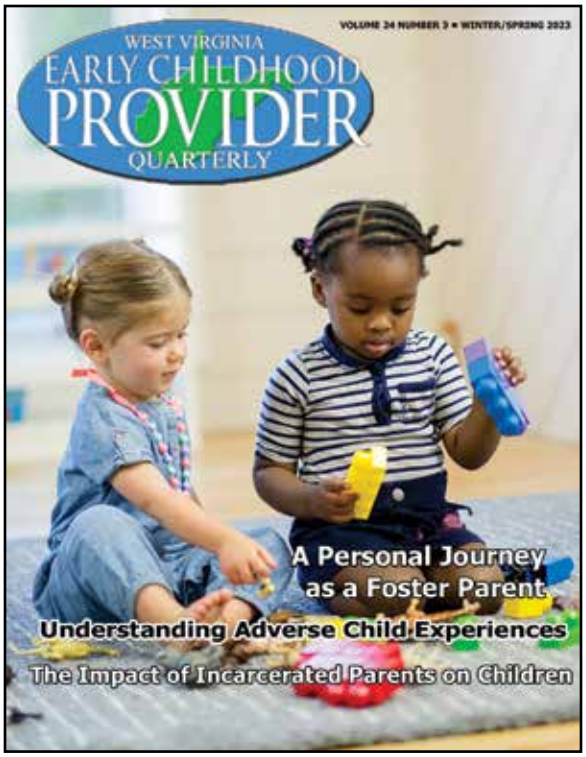

Adverse Childhood Experiences (ACEs) 101

Submitted by Lea Wheeler, Behavioral Consultant, River Valley Child Development Services

Adverse Childhood Experiences (ACEs) can come in many forms, from physical and mental abuse, to household dysfunction, to neglect in children under the age of 18. These experiences can possibly interfere with a person's physical and mental health, and stability throughout a person's lifetime. The Centers for Disease Control and Prevention (CDC) and Kaiser Permanente published a study that researched the impacts of ACEs on physical and mental health problems of adults. During this study, the adults were given a survey of 10 different types of ACEs to determine if they had experienced any of them prior to the age of 18. The study showed a correlation between a higher ACEs score and health complications. While there are many other types of adverse childhood experiences that were not included, the survey focused on: physical, emotional, sexual abuse, physical and emotional neglect, household mental illness, mother treated violently, divorce, incarcerated relative, and household substance abuse.

People who have experienced adverse childhood experiences are not damaged. No one should be defined by their ACE score. There are many ways to prevent and overcome ACEs. One of the most important ways to help prevent the impacts of ACEs is to provide safe, stable, and nurturing relationships and environments. This is a vital component to prevent child maltreatment and to assure children reach their full potential.

In lessening the impact of ACEs, we can promote resiliency in children. By promoting resiliency, we can help children "bounce back" from adversity. How can we do this? We can provide positive experiences and opportunities. These positive experiences can include providing routines in order for children to have structure, praising a child for something specifically, or even just making the time to sit down with a child and listen to him. There are many simple ways to help mitigate the impact of ACEs. Just remember, no one is defined by their ACE score and you can make a huge difference in a child's life and future.

For additional information and what you can do to help, please attend ACEs 101 and Spreading Hope. Available times and dates can be found on the WV STARS calendar www.wvstars.org.

"People who have experienced adverse childhood experiences are not damaged. No one should be defined by their ACE score."

Understanding Adverse Childhood Experiences

Submitted by Carrie Frasch, MA, Behavioral Consultant, MountainHeart Community Services

You may have heard the term ACEs often lately, but do you know what the acronym means? Adverse Childhood Experiences (ACEs) began as a study by the Centers for Disease Control and Prevention (CDC) and Kaiser Permanente in the late 1990s. The study focused on 17,000 adults facing health issues. Researchers asked participants questions focused on their childhood, and responses were grouped into three categories: abuse, neglect, and family dysfunction.

The study revealed that being exposed to childhood trauma under 18 years of age might lead to the onset of adult chronic diseases, depression and other mental illnesses, violence, and being a victim of violence, as well as financial and social problems. It also found a correlation between the number of ACEs and an increased possibility of physical and mental health issues. Research also revealed lower academic achievement, workforce productivity, earning potential, and quality of relationships.

According to the Centers for Disease Control and Prevention, it is estimated that roughly one in five children have a diagnosable mental health condition. It also estimates that one in six adults has experienced at least four adverse childhood experiences or ACEs. The great news is that the number of ACEs experienced in childhood does not have to determine a negative outcome. We can change this!

For those who work with children, understanding ACEs is vital for helping us provide the support our children need. There are many ways we can help individuals overcome trauma. The first is protective factors. Protective factors are characteristics associated with a lower likelihood of adverse outcomes. Protective factors may be seen as positive countering events (SAMHSA, 2022). Protective factors give support and structure.

Next is the need for safe, stable, nurturing relationships and environments. Safety is the extent to which a child is free from fear and secure from physical or psychological harm within their social and physical environment. Stability is the degree of predictability and consistency in a child's social, emotional, and physical environment. Nurturing is the extent to which children's physical, emotional, and developmental needs are sensitively and consistently met (CDC, 2021).

Lastly is resiliency. Resilience means "adapting" well in the face of adversity, trauma, tragedy, threats, or other sources of stress (APA, 2018). It is the ability to adjust (or bounce back) when bad things happen. It helps overcome the adverse effects that ACEs can have. Resilience won't make your problems disappear, but it can allow you to see past them, find enjoyment in life, and better handle stress. By building safe, nurturing relationships and learning to regulate emotions, we can help the brain heal, opening the opportunity to live rich, successful, and fulfilling lives while minimizing the long-term negative effects of the adverse events in our lives.

Positive relationships with children cultivate patterns of long-lasting strength and resource building. Positive relationships are also known as Positive Childhood Experiences (PCEs). You can provide positive childhood experiences by modeling calm and resiliency, focusing on what is working, creating soothing places and spaces, supporting children's friendships, encouraging hobbies, having open and honest conversations, and building a hopeful vision of the future. Remember, resilience trumps ACEs.

"Because what I know for sure is that everything that has happened to you was also happening for you. And all that time, in all of those moments, you were building strength. Strength times strength equals power. What happened to you can be your power." – Oprah Winfrey

For more information about ACEs visit the WV ACEs Coalition at https://www.acescoalitionofwv.com/

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A Village: A Personal Journey as a Foster Parent

Submitted by Debbie Smith, BA, Interim Service Coordinator, River Valley Child Development Services,
WV Birth to Three RAU IV

"It takes a village," a phrase something new parents and not-so-new parents often hear. What exactly do these well-wishers and onlookers mean? What happens if no one in said village knows what it "takes?" This is exactly what happened to my husband and I when we received the call asking us to take care of a 6-week-old, premature, and drug exposed infant. A brief 72 hours later, and we were foster parents with no experience in caring for an Neonatal Abstinence Syndrome (NAS) infant. That's when I needed my village the most.

The first week felt like a blur. I have helped care for many infants but never such a special case, no less in my home. I was lost. How could a 4lb 6oz boy cry so loud, shake like a leaf in a storm, and stay so balled up, all in a matter of minutes? An instant was all it took for the symptoms of NAS to come. Sometimes these symptoms would be fleeting, and other times the crying never seemed to stop. There's unnerving desperation in a NAS infant's cry that is not in a typical infant's cry, and it was in these moments that, as a caregiver, I knew I needed help.

Professionally, my husband and I have experience working with children and families in many capacities, but this was going to be a completely different undertaking. I was working as an education specialist in early childhood at the time, so I was familiar with Birth to Three (BTT) and was relieved when our Child Protective Services (CPS) worker told us he had made a referral. Fast forward three years, and my heart and soul reside in this program. I now work for West Virginia Birth to Three (BTT) as an Interim Service Coordinator (ISC).

During that initial visit with BTT, I was talking to my ISC about my concerns and was relieved when these worries were met with a level of understanding and compassion that

helped put my mind at ease. Help was coming, I was not alone, and my village might be growing. My ISC helped me choose a team of practitioners that had extensive experience with NAS infants and families. These practitioners would be evaluating my son to see where they could provide developmental support for him, and coaching techniques and strategies for my husband and me. Together we all created an Individualized Family Service Plan (IFSP) and that's when the work began.

First, we focused on feeding. We had a Speech and Language Pathologist (SLP), who specialized in feeding, identify a tongue, lip, and cheek tie. She showed us stretching and feeding techniques and, once again, plenty of support as I cried to her out of frustration. These ties proved to be another hurdle ahead of us. Our SLP and team assisted us in making a referral to a medical specialist who released those oral ties. His feeding progressed rapidly once he healed from the procedure.

Unfortunately, our original SLP could not stay on our team and my ISC helped me find another SLP to take her place, who eventually had the whole family using sign language since his speech was delayed as he got older. His physical therapist helped us stretch his tight muscles, which improved his body positioning immensely. His developmental specialist helped us with calming techniques and aided in monitoring all his other developmental milestones, and this was just in the first year!

The NAS symptoms showed themselves in other ways as he got older. The way he interacted with his surroundings and his motor skills were far removed from that of his peers, for instance. He is both a sensory seeker and a sensory avoider. He wouldn't sit down to play and learn, he'd get naked and spin in circles, he refused to touch grass until he was almost 2 years old, and if his hands got messy it would send him into sheer panic mode.

I let my Ongoing Service Coordinator know I had new concerns upon noticing these quirks. She listened to my concerns and assisted me in choosing an Occupational Therapist (OT) to evaluate him and add to the team if necessary, and that we did. Again, we were provided power and flexibility on who worked with our son, and we would have more techniques, strategies, and support. At 18 months of age my son had four BTT therapists providing weekly intervention services blended between home and child care. He had support wherever he went. I had support. I had my village.

Even before he turned three, my Ongoing Service Coordinator helped me with outside resources. She helped me choose a clinic for continuing his OT sessions, as well as make a referral to the school system to see if he could receive similar services in a school setting once he aged out of BTT. He was screened and scored far beyond his age. My premature NAS infant who started with multiple delays now surpasses his peers. Now that is a noteworthy statistic.

For three years my family received Birth to Three services, and my husband and I became better parents. I received coaching from these practitioners during my time with BTT and have since been able to help other families both professionally and personally. My son is turning four in six months, the NAS symptoms will always be there and still he struggles, but BTT helped set us up for success. I always want our BTT journey to be remembered as just that: a journey. We started off alone, and along the way met so many incredible people and overcame many obstacles. Birth to Three became our village.

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New Year's Resolutions for Providers Working with Children with a History of Opioid Exposure

Submitted by Pam Holland, MA-CCC-SLP/BCS-S, Associate Professor,
Chair and Graduate Program Director for the Department of Communication Disorders at Marshall University.

New Year's Resolutions are a common practice among many. By the time this edition of the *West Virginia Early Childhood Provider Quarterly* magazine is distributed, many of us have forgotten those resolutions or offered up reasons we are no longer prioritizing exercise, eating healthy, or giving up scrolling on our favorite social media sites. Even if you don't make resolutions at the start of a new year, I offer the following list of terminology, resources, and strategies to add to your professional practice as you collaborate with children and their families who have a history of prenatal opioid exposure and/or substance use disorder. Let us start with terminology most of you are familiar with. I challenge you to go back to the basics, ensure you are well versed in these evolving definitions, and ask yourself how you are appropriately applying them in your practice.

Adverse Childhood Experiences, (ACEs)

Do you really know what they are? (Physical, sexual, or verbal abuse, physical or emotional neglect, separation or divorce, a family member with mental illness, a family member addicted to drugs or alcohol, a family member who is in prison, witnessing a parent being abused). Have you taken the quiz so that you are aware of your own? If not, start here: https://americanspcc.org/take-the-aces-quiz/

Neonatal Opioid Withdraw Syndrome (NOWS)

According to Patrick, Barfield & Poindexter, (2020), NOWS is a postnatal drug withdrawal syndrome present in the first 24 to 72 hours post-delivery in exposed infants, which may include hyperactivity of the central and autonomic nervous systems and dysfunction of the gastrointestinal system. The condition manifests itself clinically in a multitude of ways, including general irritability, high-pitched crying, disruption of sleep, tremors, hypertonicity, abnormal feeding patterns, nasal congestion, vomiting, diarrhea, and poor weight gain (Kocherlakota, 2014; McQueen & Murphy-Oikonen, 2016).

Children with a History of Opioid Exposure, (CHOE)

Our research team at Marshall University coined this term for a discussion of more long-term effects. CHOE is multifaceted and encompasses a wide array of biomedical, neurobiological, social factors and characteristics.

As researchers and clinicians investigating and providing services to this unique population of children, our research team feels the following group of children may be classified as CHOE:

- Children exposed to opioids prenatally that required pharmacological treatment
- Children exposed to opioids that did not require pharmacological treatment
- Children diagnosed with NOWS following birth
- Children who have one or more members of their family who use or have used opioids
- Children who have been displaced (i.e., living in foster care, living with grandparents, or are under kinship care) due to a parent or caregiver who uses or has used opioids
- Children whose lives have been affected by the trauma associated

with a familial environment which includes opioid use, opioid misuse, or medically assisted treatment for opioid use

● Children who have caregivers in recovery from opioid use (Maxwell et al., 2022; Rutherford et al., 2022).

Interprofessional Education, (IPE)

Interprofessional education occurs when students (remember, we are all learning) from two or more professions learn about, from, and with each other to enable effective collaboration and improve health outcomes. Consider yourself a student and create a collaborative learning environment for yourself and your colleagues working with this unique population.

Interprofessional Practice (IPP)

Collaborative practice happens when multiple health and educational providers from different professional backgrounds work together with patients, families, caregivers, and communities to deliver the highest quality of care. It allows providers to engage any individual whose skills can help achieve local health and goals (WHO, 2019). It is essential we collaborate. What have you learned and how can you share this information with your colleagues? How often do you communicate with your team members who are providing services to the same family? We can all do better.

The WV Department of Education and WV Department of Health and Human Resources, including WV Birth to Three, offer a variety of resources related to NOWS and ACES, but did you know about the following books that will also improve your practice? I encourage you to start a book club. What a great way to begin IPE/IPP with a focus on CHOE! Don't know where to start? Consider these books.

Neonatal Abstinence Syndrome - Federal Prevention Role and Related Data by Russell Bailey

Addicted. Pregnant. Poor. by Kelly Ray Knight

RX Appalachia: Stories of Treatment and Survival in Rural Kentucky by Lesly-Marie Buer

I Love You, More: Short Stories of Addiction, Recovery, and Loss From the Family's Perspective by Blake E. Cohen

Childhood Disrupted by Donna Jackson Whalen

Hey, Kiddo by Jarrett J. Krosochzka

Poor Students, Rich Teaching: Mindset for Change by Eric Jensen

The Deepest Well: Healing the Long-Term Effects of Child Adversity by Natalie Burke Harris

The Body that Keeps Score: Brain, Mind, and Body in the Healing of Trauma by Bessal van der Kolk, M.D.

Fostering Resilient Learners: Strategies for Creating a Trauma-Sensitive Classroom by Kristin Souers with Pete Hall

Relationship, Responsibility, and Regulation: Trauma-Invested Practices for Fostering Resilient Learners by Kristin Van Marter Souers and Pete Hall

The Boy Who Was Raised as a Dog: And Other Stories from a Child Psychiatrist's Notebook – What Traumatized Children Can Teach Us About Loss, Love, and Healing by Bruce D Perry and Maia Szalavitz

Born for Love: Why Empathy is Essential—and Endangered by Bruce D Perry and Maia Szalavitz

The Yes Brain: How to Cultivate Courage, Curiosity, and Resilience in Your Child by Daniel J. Siegel and Tina Payne Bryson

Lost at School: Why Our Kids with Behavioral Challenges are Falling Through the Cracks and How We Can Help Them by Ross W. Greene

Beyond Behaviors: Using Brain Science and Compassion to Understand and Solve Children's Behavioral Challenges by Mona Delahooke

How to Talk So Little Kids Will Listen by Joanna Faber & Julie King

Building Healthy Minds by Stanley I. Greenspan

The Whole-Brain Child: 12 Revolutionary Strategies to Nurture Your Child's Developing Mind by Daniel J. Siegel and Tina Payne Bryson

Terminology and resources are essential, but we entered a profession of serving children out of love for them. I want to bring you back to that feeling and consider the five love languages. The book, *The 5 Love Languages,* written by Gary Chapman, was created for couples; however, the ideas apply to situations when we may feel disconnected from the people we care about and are aimed at strengthening connections. I take them out of context just a bit but when working with children, their families and other providers I am collaborating with. But isn't it worth **affirming the words** of other professionals and family members, **providing acts of service** by way of putting your verbal commitments to families into action by decreasing stigma associated with substance use disorder and sharing resources with your colleagues across multiple disciplines, **receiving gifts** in the form of education, and **giving quality time** to a topic that benefits our families who have experienced more than we can imagine so that they feel touched by a compassionate, competent and loving inter-professional care team? I think so.

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Hidden Victims: The Impact of Incarcerated Parents on Young Children

Submitted by Linda Reeves, MS, MA, LSW, IMH-E® (II), Behavior Consultant, Child Care Resource Center

The incarceration rate in the United States has increased dramatically (an increase of 500 percent) in the past half century, making the U.S. a top leader across the world for incarceration (Bureau of Justice Statistics, 2016). Unfortunately, as the U.S. prison population has surged over the past few decades, so has the number of children and families who also experience the devastating consequences of having a parent incarcerated. On any given day, 2.7 million children (or about 1 in every 33 children) have a parent serving time in prison or jail and over 5.2 million have had an incarcerated parent at some point during their lives.

According to research information from the Bureau of Justice Statistics' Survey of Prison Inmates (2016), children with a parent who is or has been incarcerated are typically younger, have at least one sibling and live in low-income families of a racial minority, usually with a young, single mother who has limited education. Most are younger than 10 years old. More than 15 percent of children with parents in federal prison, and more than 20 percent with parents in state prison, are 4 years old or younger.

The percentage of children who have experienced parental incarceration varies widely from state to state, with West Virginia among 12 states with the largest percentage of children with a parent in and out of jail (Kids Count, 2016). In West Virginia alone, 34,000 children or 10 percent of WV children are considered at risk, with a parent who has been in, or is currently in jail or prison.

An often-overlooked impact of crime and incarceration is the effect these situations have on the children of those incarcerated. Family members, especially the children, are often referred to as "hidden victims" as they are often left behind and rarely acknowledged or taken into consideration when their father, mother, or primary caregiver is imprisoned. Unfortunately, this leaves these hidden victims without the critical prevention and intervention services needed to address the potential negative implications of parental incarceration on child well-being.

Parental incarceration is a recognized Adverse Childhood Experience (ACE), a potentially stressful or traumatic childhood event that can lead to poor physical and mental health and well-being as an adult. It often occurs along with other stressors or adverse experiences, such as family economic instability, parental divorce, parental mental illness, physical or emotional neglect, and/or household substance abuse that make these families particularly fragile.

While all ACEs create some form of stress, having a parent incarcerated can lead to a unique combination of reactions related to the trauma, shame, and stigma often felt when a parent is sent to jail or prison since it involves a mother or father being removed from the child's home or daily routine. This removal of a parent may be a traumatic event for many children, especially if they witness the arrest of the parent. For other children, the removal of the parent may be a relief if there is a history of domestic violence or child abuse. In any case, a child is often left with a great deal of uncertainty and fears over how long a parent will be gone, who will care for the child/siblings, where will they live, etc. The removal is stigmatizing and can lead to trust and attachment issues, as well as isolation and shame among the child and other family members. This may limit their access to social support systems as well as connections with peers, teachers, and other critical resources.

When a parent is incarcerated, families experience a variety of challenges. Financially, families may experience additional costs and expenses related to legal fees, loss of work, increased need for childcare, etc. The family's structure and routine may change dramatically as it is common for children's living arrangements to be altered (moving to a different household entirely such as being placed in foster or kinship care, or moving to a new location). In turn, changes in living arrangements may lead to changes in the child's childcare, school, and other community programs or services. Relationships between children and family members are impacted, particularly with the incarcerated parent as contact with them may end or decrease dramatically. All of this can create a heavy burden physically and mentally on the non-incarcerated parent, and lead to less engaged and effective parenting.

Numerous studies over the years have shown the dramatic impact on a child's physical, developmental, academic, and mental health when a parent is in jail or prison. While each child reacts differently, it is important to keep in mind a child's age and developmental stage when considering the influence parental incarceration has on the child's physical and mental well-being. Children's developmental skills and needs change as they grow and develop and

it is important to keep this in mind at all times of the parent's incarceration (when the parent is arrested, throughout incarceration, and when the parent is released).

Emotionally, the impact on children is often seen in children's mental health issues such as depression, anxiety, post-traumatic stress disorder, feelings of abandonment, and grief. Some common feelings children experience include fear, anxiety, worry, sadness, isolation, anger, guilt, shame, confusion, trust and attachment issues, and resentment. Very young children often experience a wide range of intense emotions like older children, and they often express these reactions through anger and aggressive outbursts as they have fewer emotional, verbal, and cognitive skills to process and demonstrate them. Developmentally and academically, they often have difficulty with focusing and concentration, poor impulse control, difficulty with self-regulation, decreased motivation, increased absenteeism, and increased rates of suspension/expulsion, all leading to a potential decline in their developmental and academic skills.

With the staggering rate of parental incarceration and its demonstrated impact on child well-being, it is critical for those who work with children and families to recognize the prevalence of this issue and the role they can play in supporting positive outcomes and resiliency in some of our most vulnerable and forgotten children. This is particularly true for early care and education professionals who work with young children less than 5 years old, and their families, during such a vital and critical period of brain development and resiliency. More than likely, most early care and education professionals are already working with "hidden victims".

Given the unique roles in working with young children and families in a variety of settings, early care and education professionals are well positioned to provide support to children of incarcerated parents in their programs. Childcare providers, preschool teachers, home visitors, developmental specialists, speech/physical/occupational therapists, social workers, mental health providers, medical providers, etc. all can contribute to providing a variety of protective factors that build critical resilience and healing to young children/families and help mitigate the negative influences and potential traumatic implications of having an incarcerated parent.

According to the Center for the Study of Social Policy, there are five protective factors that form the foundation of the Strengthening Families Ap-

proach: parental resilience, social connections, concrete support in times of need, knowledge of parenting and child development, and social emotional competence of children (www.strengtheningfamilies.net). Research studies show that these protective factors are also "promotive" factors that build family strengths and a family environment that promotes optimal child and youth development, particularly in times of adversity such as parental incarceration. These five protective factors are critically important in supporting children/families of incarcerated parents and can be applied through a variety of avenues by early care and education professionals.

Parental Resilience

No one can eliminate stress from parenting, but a parent's capacity for resilience can affect how a parent deals with stress, particularly when another parent is incarcerated. Helping parents find ways to solve problems, build and sustain trusting relationships with their children and others, and knowing how and where to seek help when necessary helps build critical parental resilience.

Social Connections

Friends, family members, neighbors and community members provide emotional support, help solve problems, offer parenting advice, and give concrete assistance to parents. When a parent is incarcerated, these networks of support are essential to children/families, especially due to the increased stigma and isolation families feel during this time. They may need extra help in reaching out to build positive relationships which are so critical to child and family well-being.

Concrete Support in Times of Need

Meeting basic needs like food, shelter, clothing, and health care is essential for families to thrive. Likewise, when families encounter a crisis such as an incarcerated parent and other connected adversities, adequate services and supports need to be in place to provide stability, treatment, and help for family members to get through the crisis.

Knowledge of Parenting and Child Development

Accurate information about child development and appropriate expectations for children's behavior at every age help parents see their children in a positive light and promote their healthy development. During times of adversity or crisis, such as parental incarceration, it is especially important to help fam-

ilies understand developmentally appropriate reactions and supports to help guide each individual child.

Social and Emotional Competence of Children

A child's ability to interact positively with others, self-regulate their emotions/behavior, and effectively communicate their feelings has a positive impact on their relationships with their family, other adults, and peers. Adverse experiences such as parental incarceration often leads to challenging behaviors and/or delayed development which can create extra stress for families. Early identification and assistance for both parents and children can head off negative results for the child and help keep them developmentally and academically on track.

Despite all the challenges, children of incarcerated parents are some of the most resilient children, especially when communities step up and make a concerted effort to offer their support and guidance. By becoming more aware of the scope of the problem and its effects on children and families, early care and education providers can build the necessary skills to respond sensitively, recognize and support resilience, access available resources, and advocate as appropriate.

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

Asthma Action Plans

Submitted by Karen Gilbert, RN, BSN, Child Care Nurse Health Consultant, River Valley Child Development Services

"Asthma is the leading cause of chronic illness in children. It affects more than 7 million of them in the United States. Asthma can begin at any age, but most children have their first symptom by age 5" (Cleveland Clinic). West Virginia Childcare Licensing regulations state for children who have a chronic health condition, such as asthma, a medical action plan is required (WV Childcare Center Licensing). In the case of asthma, the plan is called an Asthma Action Plan. "An Asthma Action Plan is a tool to protect children from an asthma attack. Studies show children with an Asthma Action Plan are less likely to have an asthma attack in the past 12 months" (Asthma Allergy Network).

What exactly is an Asthma Action Plan?

- A written document outlining the appropriate care for a child with asthma, or in the event of a medical emergency.
- Developed by a licensed healthcare provider, along with the parents. After receiving the action plan, the childcare provider should review it with the parent.
- It includes specific approaches used to prevent or minimize any concerns identified for the child.

Why is it important to have one of these plans?

- To prepare your staff to meet the health needs of the child
- To help develop policies and procedures
- To guide plans for staff education
- To meet licensing requirements
- To meet recommendation by the American Academy of Pediatrics

What would one of these plans include?

- A brief medical history/diagnosis
- Medication or procedures required during the school day
- Triggers to avoid
- Symptoms that indicate a concern
- Who is responsible for supplies
- Any suggested special education and skill training for staff
- Contact information for the family and health care providers
- Emergency plans and procedures (including whom to contact)
- Interim measures to be taken while waiting for parents/EMS to arrive

References:

Asthma Allergy Network. https://allergyasthmanetwork.org/what-is-asthma/asthma-action-plan/ Accessed 12/22/2022.

Cleveland Clinic. Asthma in Children: Risk Factors, Diagnosis, Management. (clevelandclinic.org))Accessed 12/22/2022.

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Community and Family Services Division

Understanding Adverse Childhood Experiences (ACEs)

What are ACEs?

Adverse Childhood Experiences (ACEs) are serious childhood traumas that can result in toxic stress, causing harm to a child's brain. This toxic stress may make it difficult to learn, to play in a healthy way with other children, and can result in long-term health problems.

THE CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC) VIEWS ACES AS ONE OF THE MAJOR HEALTH ISSUES IN THE 21ST CENTURY.

Exposure to ACEs can increase the risk of:

- Adolescent pregnancy
- Alcohol and drug abuse
- Asthma
- Depression
- Heart disease
- Intimate partner violence
- Liver disease
- Sexually-transmitted disease
- Smoking
- Suicide

ACEs can include:

- Emotional abuse
- Physical abuse
- Sexual abuse
- Emotional neglect
- Physical neglect
- Mother treated violently
- Household substance use
- Household mental illness
- Parental separation or divorce
- Incarcerated household member
- Bullying (by another child or adult)
- Witnessing violence outside the home
- Witnessing a brother or sister being abused
- Racism, sexism or any other form of discrimination
- Experiencing homelessness
- Natural disasters and war

SURVIVAL MODE RESPONSE

Increased heart rate, blood pressure, breathing and muscle tension. When a child is in survival mode, self-protection is their priority.

The good news is RESILIENCE can bring back health and hope!

What is Resilience?

Resilience is the ability to be healthy and hopeful despite experiencing stressful events. Research shows that when caregivers provide physically and emotionally safe environments for children and teach them how to be resilient, the negative effects of ACEs can be reduced.

Resilience Trumps ACEs!

Parents, teachers and caregivers can help children by:

- Gaining an understanding of ACEs
- Helping children identify feelings and manage emotions
- Creating safe physical and emotional environments at home, in school and in neighborhoods

What Does Resilience Look Like?

1. Having resilient caregivers

Caregivers who know how to solve problems, who have healthy relationships with other adults, and who build healthy relationships with the children in their care.

2. Building attachment and nurturing relationships

Adults who listen and respond patiently to a child in a supportive way, and pay attention to a child's physical and emotional needs.

3. Building social connections

Having family, friends and/or neighbors who support, help and listen to children.

4. Meeting basic needs

Providing children with safe housing, nutritious food, appropriate clothing, and access to health care and good education.

5. Learning about parenting and how children grow

Understanding how parents and caregivers can help children grow in a healthy way, and what to expect from children as they grow.

6. Building social and emotional skills

Helping children interact in a healthy way with others, manage their emotions and communicate their feelings and needs.

Resources:

1-2-3 Care Toolkit
srhd.org/1-2-3-care-toolkit

ACES 101
acestoohigh.com/aces-101

CDC Parent Information
cdc.gov/parents

CDC Kaiser Adverse Childhood Experiences Study
cdc.gov/violenceprevention/acestudy

Community Resilience Initiative
criresilient.org

aces
ADVERSE CHILDHOOD EXPERIENCES COALITION OF WEST VIRGINIA

ACEs Coalition of West Virginia
One Creative Place, Charleston, WV 25311
304-205-5685 • info@wvaces.org • www.wvaces.org

SPOKANE REGIONAL HEALTH DISTRICT

Indoor Physical Activities

Submitted by Renee Y. Stonebraker, RS, Child Care Health Educator, River Valley Child Development Services

Here are some activity ideas to get children moving!

- Throw a soft ball into a bucket and vary the distance
- Play Musical chairs
- Set up crazy golf – a golf course using household items
- Have a dance party
- Follow the leader games
- Make an obstacle course
- Practice kicking and throwing using a soft ball
- Play 'Head, Shoulders, Knees and Toes,' 'Hokey-Pokey,' and 'If Your Happy and You Know It'
- Act out a story
- Bowl using a soft ball and empty water bottles
- Jump over a piece of rope or yarn
- Play hopscotch

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

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.

"Providing resources to parents throughout West Virginia"

Volume 19, Issue 1, Winter/Spring 2023

Caring for Substance Exposed Babies

Submitted by Jackie Martin, Occupational Therapist

Neonatal Abstinence Syndrome/ NAS is a medical term used to describe a set of symptoms of a newborn going through substance withdrawal. Exposure to many drugs in utero can pass through mom's placenta to the baby. These may include nicotine, alcohol, cocaine, heroin, LSD, anti-depressants, crystal meth etc. Opioid (morphine, pain medications) exposure to unborn fetus can result in NOWS/ Neonatal Opioid Withdrawal Syndrome.

Babies exposed to opioids seem to have more symptoms and more severe symptoms. Doctors may use the Finnigan Scale to rate the newborn baby's withdrawal symptoms. These symptoms may include:

- Low birth weight
- Diarrhea/vomiting
- High pitched crying
- Seizures/ tremors
- Hyperactive reflexes

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.

- Poor feeding
- Difficulty with sleeping
- Irritability
- Rapid heartbeat
- Excessive sudden movements
- Easily Frustrated
- Moro Reflex
- Difficult to console
- Delay with motor development
- Impaired social skills
- Poor self-regulation

The "Eat, Sleep, Console" Model is an evidence-based method of care that helps new moms care for their infant who may have been exposed to substances. The model provides family-centered care. This enables mom and baby to stay together so babies can feed on demand and be rocked and cuddled as much as possible.

Eat: Is the baby feeding normally?
Sleep: Is the baby able to sleep between feedings?
Console: Can the baby be consoled/comforted within 10 minutes of crying?

Sometimes medical treatment may be needed. This includes:

- Anti-seizure medication
- IV fluids due to diarrhea and dehydration
- Higher calorie formula
- Sensitive formula due to GI concerns
- Oral morphine, oral methadone or Subutex when baby cannot tolerate routine care by nurses (Nurses monitor vital signs, sleep, eating and behavior and gradually wean off).

Caring for babies experiencing NAS requires additional awareness and care, particularly regarding feeding, sleeping, and soothing.

Feeding

Smaller and more frequent feedings are recommended for babies experiencing NAS due to difficulty feeding because of poor latch, uncoordinated suck and swallow patterns, the baby needing to pause and breathe between swallows that can lead to air/gas build up, and long feeding sessions.

Good bottle suggestions include:

- Dr. Brown's Natural Flow Bottles which includes an internal vent system to provide a natural slow flow to help reduce gas, spit-up and colic.

- Tommee Tippee Advanced Anti-Colic Bottle, this wider bottle may be easier to clean and comes in a set of 2-8 ounces.

Prior to feeding, swaddle the baby to minimize external stimulus. This will help the baby relax and prevent auto-stimulation (Moro reflex). It may also help to dim the lighting and feed the baby in a quiet environment.

Sleeping

Swaddling the baby provides comfort and calm and prevents flailing arms, providing a "womb" like support.

Suggestions for swaddling include:

- Muslin swaddle - you can fold yourself
- The Swaddle Me sleep sack - thin, breathable fabric making it ideal if the baby becomes hot and sweats a lot, which is a common occurrence with substance-exposed babies.
- HALO sleep sack - wider at the bottom for more leg movement.
- Merlin Suit - weighted sleep suit

Other considerations for sleep may include:

- Cuddling, which stimulates the brain development and bonding
- Elevating the baby's head during sleep to help with better breathing and digestion
- Using a humidifier to ease respiratory concerns and autonomic dysfunction, which can lead to congestion and coughing (Geniani is highly rated on Amazon)
- Using saline spray and a bulb syringe to clear nasal passages
- Using a pacifier. Due to excessive sucking when experiencing withdrawals, the baby may develop blisters on their knuckles and hands. A good pacifier can prevent this. It also

helps the baby self-soothe due to rhythmic sucking. Tommee Tippee Nighttime Pacifier has a great shape for a little one's mouth and has a glow-in-the-dark handle.

- Using a white noise machine or Baby Shusher Sleep Miracle Soother, which plays a low, rhythmic shushing sound in response to baby's cry to help him engage his natural calming reflex.
- Using a vibrating mattress pad such as Munchkin Lulla-Vibe- This pad can be placed under the crib mattress for gentle vibrations to lull the baby to sleep.

Sensitive Skin Care

Loose stools or diarrhea due to withdrawals and toxins can lead to diaper rash. A substance exposed baby's skin is 30 percent thinner and retains more moisture in the diaper area causing severe rash. Because of this, it is important to:

- Do frequent diaper changes (every 1-3 hours)
- Use super absorbent diapers
- Use dry wipes moistened with sterile water (such as Medline Ultrasoft Dry Cleansing Wipes)
- Apply a thick layer of diaper cream: Aquaphor and Desitin Maximum Strength (purple box) for mild to moderate rash, or Marathon Liquid Skin Protectant for more severe cases (prescription from doctor required)
- Calmoseptine Ointment available on Amazon.

For babies experiencing eczema, you may try Aveeno Baby Eczema Therapy to reduce irritation and itching.

Consoling

There are several calming strategies that you can use including,

- Skin-to-skin contact
- Gentle massage
- Rocking baby
- Swaying the baby in arms
- Hold baby with rhythmic bouncing (up and down)
- Baby Carrier- Moby Wrap (0-36 months)
- Low stimulation
- Cuddling

Swings can also help in soothing a baby. Swings provide slow linear vestibular movement for calming input.

Or try a Mamaroo, which allows you to program different movements to help provide rhythmic vestibular input, adjust the speeds, and choose white noise.

Another choice is the Fisher Price Rock 'n Play, which provides incline seating and vibration for calming input.

Try to remain calm so your baby does not feed off your anxiety:

- Take deep breaths
- Keep a low voice
- Don't be afraid to ask for help
- Attend support groups

Believe in yourself and your precious little one! You can do this!!!

Citations

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Care for yourself one small way each day

Take breaks to relax and unwind through yoga, music, gardening, or new hobbies

Find new ways to safely connect with family and friends, get support, and share feelings

Take care of your body and get moving to lessen fatigue, anxiety, or sadness

Treat yourself to healthy foods and get enough sleep

Substance Abuse and Mental Health Services Administration
Disaster Distress Hotline: call or text 1-800-985-5990

cdc.gov/coronavirus

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