Poly Substance Exposure:

- Increasingly common
- Can be combination of effects outlined above, often more severe symptom presentation
- Deficits in language, attention, areas of cognitive performance, and behavior challenges
- Brain imaging studies - changes in front striatal circuitry and smaller neural anatomical structures
- Lower IQ (yet not statistically significant)

Trend in Recent Years in San Diego

- Methamphetamine most common source of exposure
- Increase in rise of opioid and poly-substance exposure
- Infants with documented exposure not always removed at birth
  - Voluntary services through Child Welfare Services
- Highly variable outcomes for infants based on Mother’s involvement in treatment
- For mother’s who did not engage or maintain treatment services, high likelihood of infant being removed within next several months

Impact of Substance Use on Parental Care

Parent with impaired ability to:

- Provide appropriate care, supervision
- Read and consistently respond to child's cues

Formation of insecure attachment relationships (Internal Working Models; reality testing)

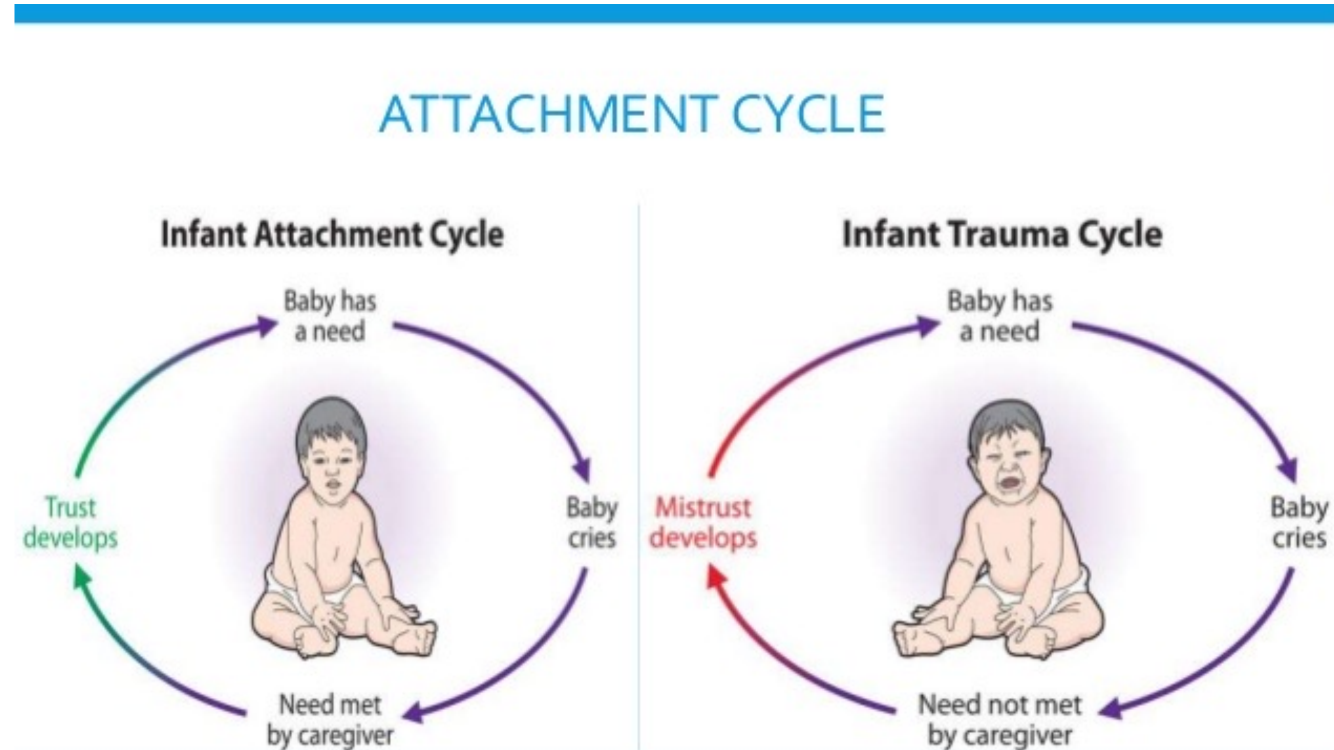
Domestic Violence

Increased likelihood of neglect and abuse (from parent under influence or other users with access to child)

Increased risk of sex trafficking of child

Safety of environment / environmental exposure

Impact on Attachment



A.Rambeau, LCSW; MS (2021)

An “Unsolvable Problem”

When the caregiver is *both* the source of protection / safety *and* the source of fear

Brain stem (threat detection) signals for the child to go away from the threat, limbic system says go toward the threat for protection

Part III: Concrete Care Strategies

- Common Specialty Medical and Developmental services
- Guiding Principles
- Concrete Care Strategies for Birth to 2 y/o
- Concrete Care Strategies for 2-5 y/o

Specialty Medical Care

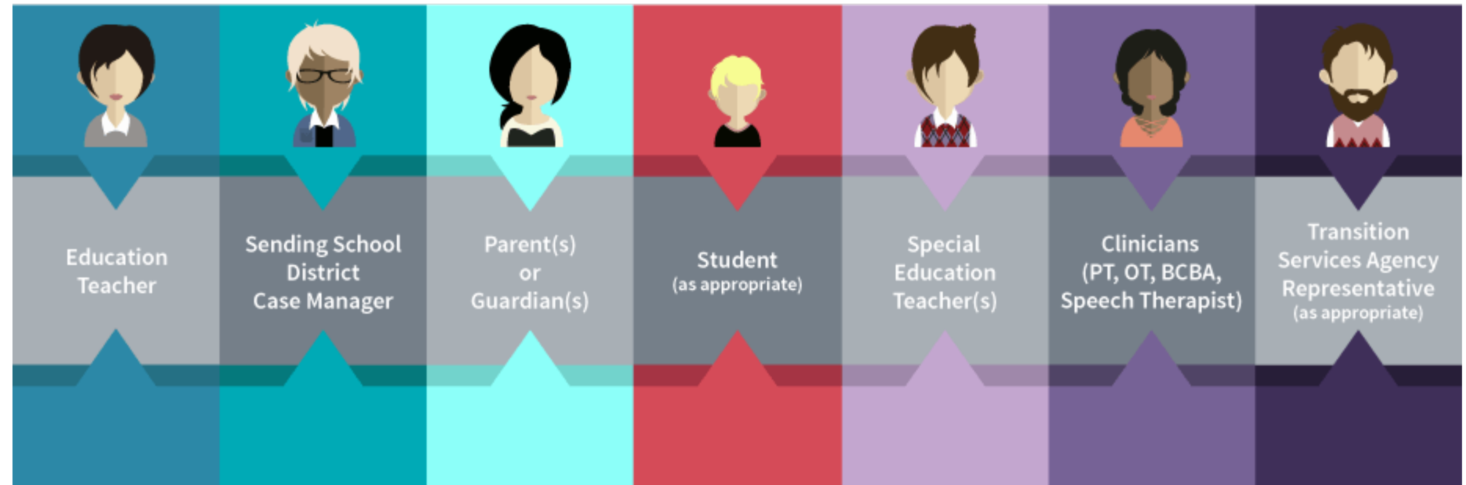
- Developmental and Behavioral Pediatrician
- FASD Clinic
- Genetics / Dysmorphology
- *G/I Specialists*
- High-Risk Infant Clinic
- Neurology
- *Dermatology*
- Rehab Medicine
- Ophthalmology
- Feeding Team

Developmental & Behavioral Services

- Occupational Therapy (especially for sensory processing)
- Physical Therapy
- Speech Therapy
- Behavior Therapy
- Infant Education
- Infant Massage (DSEP)
- Dyadic play therapy (e.g., Child-Parent Psychotherapy)

Special Education

- Individualized Education Program
- Regional Center Services
- 504 Plan for behavior
- Role of an Educational Advocate
- Importance of communication with teacher or childcare provider



Guiding Principles for Providers:

- Clients and families with complex needs tend to require more intensive services and care from the provider
- Cultivating a healthy work / life balance and robust self-care strategies
- Role of reflective practice and clinical supervision
- Coordinate with other providers to extent possible
    - Minimize contradictory suggestions or strategies
    - Broadens lens of understanding child

Strategies for Working With Caregivers:

- Meet the caregiver where they are at
  - Role of validation “Name it to tame it”
- In-vivo psycho-education, coaching, modeling, skill building
- Supporting parental self-efficacy
- Promote attachment relationship by drawing attention to and labeling child’s cues and needs
- Mindfully attend to strengths, new milestones, magic moments (e.g., child pointing their finger)
- Collaborative exploration around how to best channel energy into aspects of child’s care that can be controlled (e.g., love and nurturance in home setting)
- Parallel process – Relationship between provider and caregiver and that of caregiver and child
  - If goal is to increase praise / encouragement in caregiver – child interaction, start increasing raise / encouragement in provider – caregiver interaction

Guiding Principles for Caregivers:

- Develop a team of helping professionals
- Have a regular routine for self-care
- Utilize your support system
- Maintain a realistic yet positive attitude
- Build on child’s strengths and resiliency
- Establish predictable routines for child
- Advocate for child's educational needs

Advocacy & Organization Strategies

- Have a centralized notebook for medical forms, handouts, notes
- Take notes on changes, concerns, progress, or regression
- Bring to Dr appointments so you can speak in detail about symptoms and take notes on their feedback / suggestions
- Keep medication log
- If concern about weight gain, keep feeding log
- *For the following care strategies, always defer to medical advice from the pediatrician or specialty care provider*

Ages Birth to Two

Care Strategies for Newborn Phase:

- A nurturing, calm, consistent, and patient parenting style
- Kangaroo (skin-to-skin) care, supports the regulation of the nervous system (start in hospital if possible)
- Set up nursery as "sensory sanctuary" (e.g., black out curtains, basic décor, white noise machine)
- Observe child's stress signs and cues
- When child is fussy, take time to self-regulate and breathe deeply before trying to calm baby
- Try a soothing strategy several times before moving on to a new one

Dr. Karp's 5 S's

Fussiness: Soothing Through the Senses

Sound: soothing sounds such as a sound machine, shushing, singing, humming

Sight: reduce visual stimulation in infant's room, can also try sunlight and fresh air. Position baby facing away

Touch: Gentle ventral pressure (hand on chest or chest to chest), baby wearing, swaying, rhythmic motion.

Smell: A transitional / comfort object, soothing scents – lavender or chamomile

Sucking: Non-nutritive sucking (e.g., pacifier for birth to 6 months)

Swaddling (highly regulating, discontinue when baby begins to roll)

Tools for Soothing

- Rocking chair
- Large medicine ball for rhythmic bouncing
- Transitional object
- Vibrating teethers
- As child moves towards toddler phase sensory play is very important – stress ball, water play, kinetic sand (all with close supervision)

Feeding Challenges

- *Always consult with your Pediatrician 1st*
- Exposed infants often develop formula intolerance and require prescription formula (e.g., alimentum)
- Feed in smaller increments (2 ounces then burp)
- Try alternate burping postures
- Holding upright for 15-45 minutes after feeding
- Gas drops and gripe water
- Document frequency of spit up and vomiting for Dr

Sleeping Challenges

Minimize sensory stimulation in nursery

Follow consistent routine for sleep (builds sleep associations in brain)

Sound machine with white noise

Gradually put baby down in crib in content sleepy state vs. asleep

Babies who have been meth exposed may sleep in shorter increments more often

Babies who have been heroin exposed may over-sleep and need to be up-regulated to feed (stroking baby from feet upwards, holding baby and lifting them up and down)

For babies that sweat while asleep, can help to use cotton or linen crib sheets, cotton sleep sack

Supporting Development of Attachment Relationship

- Feeding and soothing are prime connection times
- Promote child's sense of felt safety:
  - Prepare child for physical touch and movement (minimizes startle response in nervous system)
  - Talk child through what comes next (e.g., I'm going to change your diaper)
  - Narrate their needs and reactions
- Maximize shared positive affect (e.g., activities that inspire joy for both)
- Support balance between connection and exploration (secure base behavior)

Supporting Development

- When child is in quiet or active alert state is their prime learning time
- Singing to baby helps them separate parts of speech
- Infant massage (interoception)
- Floor time and sensory play
- Repetitive and predictable play

  (e.g., peek-a-boo)
- Provide opportunities for skill mastery (e.g., dump and fill play)

Ages Two to Five