Webinar #8: Supporting Families Affected by Opioids and Other Substances through Infant and Early Childhood Mental Health Consultation Questions and Answers

Q: Where can I access the articles and references Dr. Chasnoff mentioned?

A: You can request references and copies of specific articles at the NTI Upstream website.

Q: What is the process for including a Head Start program in the services to families, and what hurdles do you commonly see?

A: Head Start seeks to provide comprehensive services to children and their families. If a family identifies substance use as a concern, the family support worker can provide support to the family and can refer them for appropriate substance use treatment services or other related services. It is optimal if the substance use treatment is family-centered and the Head Start staff can collaborate with the treatment providers as needed to help promote healthy parenting and family relationships.

Head Start staff should be aware of common hurdles to receiving substance use disorder services, including waiting lists for treatment, lack of treatment options, inaccessibility of viable treatment options, the individual’s readiness (or lack thereof) to engage in treatment, and the stigma associated with substance use disorders. When there is a good working relationship, Head Start staff can sometimes play an important role in supporting a parent to make the choice to enter treatment, as well as stay motivated if services are not immediately available. Head Start staff can also acknowledge and support a parent’s desire to do their best for their child in spite of challenges, and reinforce that getting care for themselves will benefit their child and his/her development.

Substance use disorders often co-exist with other adversity and can cause significant stress in family relationships. Head Start can support children and families by obtaining services for their other needs (housing, medical care, insurance applications, nutritional assistance or food pantries, education, employment, counseling, heating assistance, etc.), even if the family does not obtain substance use disorder treatment.

Q: How can you get a home visitor referred to a home? Is it through the local community social services department?

A: Every state’s home visiting referral process is different. Some states have centralized intake at the state level, and others may have it at the tribal or community level, offered through a local health department or social services agency. If you are not sure whom to contact about a referral for home visiting services, start with the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program lead in your state. You can find your state’s lead under “Home Visiting Program: State Fact Sheets” on the Health Resources and Services Administration (HRSA)’s website.
Q: Where can we get training on the 4P’s Plus©?

A: You can learn more about the 4P’s Plus, a screening instrument designed to quickly identify obstetrical patients at risk for use of tobacco, alcohol, or illicit drugs, by visiting the NTI Upstream website.

Q: Is the 4P’s now a 5P’s tool?

A: No. The 4P’s Plus© is a specific instrument, the only one that has been validated and published in a peer-reviewed journal. You can find out more about its research background and development at the NTI Upstream website.

Q: Since home visiting is a voluntary service, and parents with substance use disorders often fear someone coming into their home, how do you engage parents with substance use disorders in home visiting services?

A: Engaging and enrolling harder-to-reach families, such as those with substance use disorders, is challenging. Home visiting programs use various strategies, such as motivational interviewing techniques to collaborate with participants, and program flexibility to meet individual participant’s needs.

Q: Do most home visiting programs provide services to mothers who have an active substance use disorder but are not currently in substance use treatment?

A: Home visitors support families with many issues. In the case of substance use, home visitors do not provide treatment. Instead, they help mothers understand how their substance use affects young children, and they help connect families to substance use disorder treatment. This can be a challenging task, and Infant and Early Childhood Mental Health (IECMH) consultants can support the home visitor during this process and assist in identifying approaches, treatment options, and ways to continue to connect and further develop the essential relationship with the families.

Q: What do home visitors do when a woman in their caseload becomes pregnant with a second child and has an active substance use disorder?

A: Illinois’s MIECHV uses the 4P’s Plus tool to screen prenatal mothers, provide a brief intervention, and offer referrals. If there are safety issues, programs should follow mandated reporting requirements.

Q: How do home visitors maintain their trusting relationship with a family when they have concerns about child safety and, as mandated reporters, believe that they need to make a report to child welfare?

A: Home visitors should inform families of their requirements as mandated reporters from the very beginning of their relationship and consistently remind them of the limits of confidentiality within these requirements. This transparency may help to maintain the relationship when there are issues that require a report to child welfare. In some circumstances, if appropriate and safe, home visitors may involve the client in the process by asking if they would like to be present when the report is made and by keeping the family informed about the process. It
is important to research what the law and requirements are in your county or state regarding reporting. Mental health consultants working with home visitors may also be able to help them strategize about how to communicate to a family that they are there to offer non-judgmental support while working to ensure the safety and wellbeing of all family members. The IECMH consultant offers a safe place for the home visitor to process the responses and reactions that surface when dealing with such complicated issues, such as emotions and secondary trauma associated with possible safety and child abuse or neglect issues.

Q: How do consultants support home visitors when they identify a family with an active substance use disorder that is untreated? How do they assess safety and determine when to reach out to child welfare?

A: Each situation with a family is unique, and no single response applies to every situation. In their work to support families, home visitors must address many multi-faceted and complicated issues. The IECMH consultant collaborates with the home visitor to determine the next steps in working with each family. Together, they ensure that services comply with all applicable regulations (such as child welfare requirements), and they consider the impact of services on the child in each situation. Consultants help home visitors by providing a safe space to walk through each story. Consultants use their training and experience in infant and early childhood mental health to work together with the home visitor to determine the best way to address the concerns. Consultants can help home visitors develop strategies to talk with families about substance misuse in a manner that will enhance their relationship with the family and facilitate referrals to treatment and other assistance.

Q: Do you have resources for families with toddlers and preschoolers who were born addicted and now have a variety of behavior issues?

A: You can find a wide range of resources and materials at the NTI Upstream website. In particular, take a look at Making a Difference: Caring for the Infant Prenatally Exposed to Alcohol and Drugs, a handbook for parents caring for an infant with prenatal substance exposure that specifically addresses Neonatal Abstinence Syndrome (NAS). Other helpful resources include Dr. Chasnoff's book The Mystery of Risk, which provides information on behavioral interventions, and Cause & Consequence, an online behavioral management tool for children ages 5 and older.

Q: Are there any resources for training and technical assistance staff to use to support grantees in supporting families?

A: The MIECHV Technical Assistance provider is HV-ImpACT, which is led by Education Development Center, Inc., in partnership with the Georgetown University Center for Child and Human Development, Change Matrix, Brigham and Women’s Hospital, and the American Academy of Pediatrics. You can find more information on HRSA’s website.

Q: When will the tip sheets related to opioids from the Center of Excellence on IECMHC be released?

A: The tip sheets will be released by the end of August 2018. To receive notifications when we release new
Q: Does opioid use result in a permanent reduction in oxytocin? Or can oxytocin levels increase after treatment and abstinence?

A: Although there is no specific research addressing this question, from the physiology it seems that there is not a permanent reduction in oxytocin levels due to opiate use.

Q: Due to polysubstance use, how certain are you that effects on infants are due to opioids versus other substances that are often used with opioids?

A: It is quite true that polysubstance use is the rule rather than the exception. Opiate-exposed infants display different patterns of neurobehavior than infants who are prenatally exposed to other substances. However, the only way to completely determine this differentiation would be through a randomized controlled study in which half the pregnant women are given opiates and half are not. Obviously, that is a study that cannot be done.

Q: What are some common misdiagnoses besides ADHD?

A: A wide range of diagnoses are given to children and teens with prenatal alcohol and drug exposure. For a complete list of diagnoses, you can request and obtain a copy of an article that addresses young people who met the criteria for Fetal Alcohol Spectrum Disorders but were polydrug-exposed at the NTI Upstream website.

Q: If the orientation is toward non-pharmacologic care regardless of actual diagnosis, is there a downside to NAS diagnosis for all opioid-exposed newborns? In our state, this diagnosis provides automatic eligibility for Part C services, so there is a benefit to it.

A: The most recent Medicaid policy statement defines NAS as infants affected by exposure to a wide range of substances, not just opiates. It is Dr. Chasnoff’s personal opinion that this is inappropriate and just muddies the waters. In addition, a good number of opiate-exposed newborns do not meet the criteria for NAS, and labeling them as such is incorrect practice. Ideally, there would be other ways for families to access Part C services.

Q: How can medical providers differentiate between newborns with NAS vs. neurobehavioral difficulties? Is it the absence of gastrointestinal (aside from dysmature swallowing), respiratory, and autonomic nervous system dysfunction that identifies children with only neurobehavioral effects?

A: A full differentiation requires a thorough infant neurobehavioral assessment, which in most communities is not available. The most important question is whether the infant actually was exposed to opiates. If so, then you can move forward with considering a diagnosis of NAS. Unfortunately, there are infants diagnosed with NAS who never were exposed to opiates but are treated as if they were. This only sedates the infant and exposes him or her to unneeded and inappropriate medications.

Q: How well does Parent-Child Interaction Therapy work with older children?
A. The information in this webinar was targeted for children pre-birth to age 3, the age when home visiting is most often available to families. For services to older children, please refer to your state’s Department of Mental Health. To learn more about Parent-Child Interaction Therapy, visit [PCIT International](#) and for information about training, visit the [PCIT Training website](#).

**Q: Where is the research showing that an opioid user’s dopamine never rebounds completely?**

A: These data are available in a variety of articles in the substance use disorder literature. You can request references and copies of specific articles at the [NTI Upstream website](#).

**Q: If a child is exposed to opioids prenatally, is there a permanent decrease in the child’s dopamine receptors? Or does the brain do a work-around by producing more dopamine?**

A: There is no information on long-term dopamine functioning in prenatally exposed infants.

**Q: Is a fetus affected by a mother’s use of methadone?**

A: Methadone crosses the placenta readily, and infants with prenatal methadone exposure can meet criteria for a diagnosis of NAS.

**Q: What about fathers? Why is there not more of an emphasis on the effect of paternal substance misuse on a child’s development after birth?**

A: Any substance a man takes will cross into the semen, and the level of that substance in the semen can be measured. Some limited studies demonstrate that the primary effect of substance misuse is killing the sperm; those that survive have decreased motility. The one study on this topic showed that paternal alcohol use resulted in a statistically reduced mean infant birth weight. A number of epigenetic studies of paternal substance use are currently being conducted and new data are emerging, but currently there is no information regarding the clinical impact of the father’s use of opiates on child outcomes.