Newark, New Jersey

Historical overview

Newark is located within easy travel, albeit often congested, distance of New York City in northern New Jersey. Newark was mostly farmland until the early 19th century when the industrial revolution transformed it into a manufacturing hub (Turner & Koles, 2001). The population of Newark grew as the demands for manufacturing increased bringing in waves of immigrants, first the Irish and later Germans (Turner & Koles, 2001). With the start of World War I, war-related industry drove the demand for labor even more and there was an influx of African Americans from the South with a third of Newark's population African American by 1960 (Turner & Koles, 2001).

IMAGE: Peddie Memorial Baptist Church (Courtesy of Matt Gosser)

Newark experienced economic downturns first with the Great Depression which hit Newark's businesses hard and prompted an exodus of people who could afford to move. This was intensified in the aftermath of political turmoil in the 1960s leaving behind pockets of concentrated poverty. Businesses moved out or closed down which led to very high unemployment rates (Turner & Koles, 2001). Although after the end of World War II the US economy rebounded, it was the suburbs around Newark that benefitted the most from the economic upswing (Boudless.com, 2017). Massive investment in infrastructure and housing facilitated by zoning laws and strengthened of the mortgage market benefitted the suburbs (Boudless.com, 2017). Urban areas, like Newark, were considered a poor financial risk and policies like redlining led to disinvestment in the center city. This led to hypersegregation, a form of racial segregation characterized by geographical grouping of racial groups, of African

Americans, particularly those living in poverty in urban areas including Newark (Boudless.com, 2017). **IMAGE: Hahne's Building Before Redevelopment (Courtesy of Matt Gosser)**

Socio-demographics

By 2015 the population of Newark was 279,793, maintaining its status as the largest city in New Jersey. Population loss had stabilized and the net migration rate was positive (1.7%). Much (48%) of the population was African American, the second largest group (36%) was Hispanic while 11% were White. Approximately 29% of the population was foreign born. The population was evenly split between males and females. Nearly 29% were under the age of nineteen, while 9% of the population was over 65 years of age. The median age was 32 years old (Census, 2015).

In addition, there is a large population which is transient. With seven regional and national corporations' offices and an international airport located in Newark, the daytime population (commuters) increases by 55,825 (+19.8%) people (citydata.com, 2015). In addition, there are campuses of six universities/colleges in Newark which serve approximately 15,000 students who reside in or commute to Newark (citydata.com, 2015).

IMAGE: New Jersey Institute of Technology (Courtesy of Matt Gosser)

Social and Community Context

There were 92,675 households, 63% of which were family households. The average family size was 3.6. Of these 39% were families with children under 18 and 20% with people over the age of 60. The most prevalent types of families were comprised of couples (26%), mothers alone (17%) and fathers raising children by themselves (4%). Others included single individuals with no children. There were many grandparents (36%) responsible for grandchildren who were under 18 years of age; 82% of whom were females. Half of population had never been married (Census, 2015).

The population is quite diverse and includes people from Europe, Asia, Africa and Latin America. The largest (4.2%) were Sub-Saharan African, 3.9% Portuguese, and 3% West Indian.

Economic Stability

In 2015, half (51%) of Newark's population was employed and the median household income was $33,139. Compared to the median income, $72,222, of New Jersey overall this was almost half. The unemployment rate was 18.4% and 30% lived below the federal poverty line. Different neighborhoods differ by socio-economic factors; areas such as University Heights have the highest median income with 72% employment and 54% of the population educated at the bachelor's level. Areas of low socio-economic status, Lincoln Park, have lower employment rates (44%) and education (6% with bachelor's degrees).

Children in Newark fare worse than the general population with 69% living in low income households and with 18% living in extreme poverty. According to one estimate 25% of children in Newark are food insecure (Brownlee, 2010). Most public school students (74%) qualified for free lunch prompting the school system to offer free breakfast to all students recently (Thomas, 2017).

Many Newark's households, 57%, spend more than 30% of their household income on rent. Essex County, of which Newark is part of, has the most homeless residents in New Jersey. The homeless counted in Essex County are mostly African-American, more than 80% and 22.5%

are children under the age of 18. The principal reasons for homelessness here are in rank order: asked to leave shared residence, eviction, and released from prison or jail.

Education

Early childhood development and education is occurring in Newark. Per the State of New Jersey Early Intervention Services 2014 report, there were 76 Newark children enrolled in early intervention services by age 12 months, 100 children enrolled by age 24 months, and 700 enrolled prior to their third birthday. There were 6,404 Newark children enrolled in public preschool in 2012–2013 (ACNJ, 2014). In 2011–2012, the Newark preschool enrollment included 3-year-olds (46%) and 4-year-olds (54%). Approximately 82% of the children were in community classrooms such as child care centers, with approximately 18% educated within school district classrooms (ACNJ, 2013).

Newark has enormous literacy challenges in its school-age population as well as for adults. According to City of Newark Read and Believe (2015) more than half of all students (56%) are not proficient on standardized literacy tests. Most (90%) of those children who are not proficient come from economically disadvantaged families. These literacy statistics place Newark in the bottom 6% of all school districts in New Jersey (Believe, 2015). Furthermore, a third (35%) of Newark's adult residents had completed high school, however 14% reported a ninth grade education or less while 13% reported a bachelor's degree or higher (Census, 2015).

More than half (53%) of Newark's residents speak only English. Approximately 32% of residents over age five speak Spanish at home with more than half (52%) of those Spanish speakers reporting that they speak English less than "very well." Portuguese is spoken at home by approximately 7.7% of residents and more than half (57%) of those Portuguese speakers report that they speak English less than "very well." African languages are spoken at home by 2.4% of residents with 24% of those African language speakers reporting that they speak English less than "very well" (Census, 2015).

Health and Healthcare

Although most Newark residents (75%) had some kind of health insurance (Census, 2015), the burden of disease was high. According to the Behavioral Risk Factor Surveillance System (BRFSS) survey a third (33% N=468) of respondents had chronic hypertension, 15% Type II Diabetes while only 24% reported having had a routine medical exam in the last 12 months and 20% rated their health as 'poor' in 2015 (NJBRFSS, 2015). In one survey, nearly a third of the respondents rated the quality of life in Newark as positive, but another third rated it negative (SHCI, 2014). The rates of obesity and overweight were high, but among children between 3 and 11 years of age they were very high (45%-47% respectively) (Brownlee, 2010). Elevated blood lead levels are another concern among children under the age of six, where 15% of children tested positive in 2014, and the highest in the State of New Jersey (NJDHPS, 2014). With 1 in 32 African American residents affected Newark has one of the highest prevalence rates of HIV/AIDS (NJBRFSS, 2015). Rates of asthma were also high among both adults and children (NJBRFSS, 2015). The racial distribution of disease clearly indicated that the health of African American Newark residents was worse when compared to other groups. Approximately 18% of Newark residents are living with a disability, but for those 65 years or older the proportion was 50% (Census, 2015). Per 500 Cities data, 16.1 % of Newark adult residents report having "not good" mental health.

A 2015 evaluation of healthcare services in Newark found that there was surplus of inpatient beds, substantial duplication of services, few unique services, few ambulatory services, challenges to solvency, aging facilities, aging and unorganized physician population (NJHCFFA, 2015). Additionally, there was a high degree of fragmentation in the organization and delivery of healthcare. There were no formal relationships between hospitals and post-acute care providers, contributing to poor continuity of care after discharge (NJHCFFA, 2015).

Neighborhood and Built Environment

Newark's housing stock is one of the oldest in the region. In 2015, there were 109,520 housing units with 86% occupancy leaving many unoccupied and some abandoned properties.

Home ownership was low (22%) when compared with 78% who were living in rented homes (Census, 2015). Public housing included approximately 7000 units. Around 2008 Newark was impacted seriously by the crash of the housing market with numerous foreclosures and people losing their homes (SHCI, 2014). Foreclosure proceedings peaked in 2009, when a foreclosure was filed on one out of every 13 homes in the city (SHCI, 2014).

Newark has several thriving neighborhoods. The Census uses tracts to collect data but neighborhoods are spaces defined by social attributes that distinguish them from surrounding areas (Spielman & Logan, 2013). The 'ironbound' district, so named because it is bounded by railroad tracks, is composed of tracts with large immigrant, Hispanic and Portuguese populations. It has a cultural flair with ethnic restaurants and shopping.

IMAGE: New Jersey Performing Arts Center (Courtesy of Matt Gosser)

Crime is a serious concern in Newark. Although violent crime (includes murder, assault, rape, theft) rates have declined over the years, there were 9,065 incidents in 2016 (down 13% from 2015), it is still three times the national average per 100,000 residents (Moriarty, 2016). According to a 2014 report more people reported feeling safe inside their homes, but nearly 50% did not feel safe in the streets or public spaces (Hahn, 2014). Hearing gunshots (74%) and seeing drug deals (56%) in the neighborhood were common (Echeverria, Kang, Isasi, Johnson-Dias, & Pacquiao, 2014). Such factors contribute to low levels of physical activity even when people have access to parks.

IMAGE: Essex County Courthouse (Courtesy of Matt Gosser)

Although there are many supermarkets and convenience stores, fresh fruits and vegetables are in short supply and it is expensive to shop in Newark. In one survey nearly 50% of parents reported shopping for groceries in other vicinities and the top reasons were cost and quality of products (Brownlee, 2010). There are several fast food options available; 27 Dunkin Donuts, 10 McDonald's etc. (citydata.com, 2015).

Newark is a transit hub with Newark Liberty International airport, Pennsylvania Station, Greyhound, New Jersey Transit and Amtrak stations. It is surrounded on all sides by major regional highways (Newark, 2016). In addition there are three active superfund sites, a remnant of the city's industrial past (Newark, 2016). All these contribute to the poor air quality in Newark (Air Quality Index was 172 in July 2013, compared with 75 average nationwide) (citydata.com, 2015).

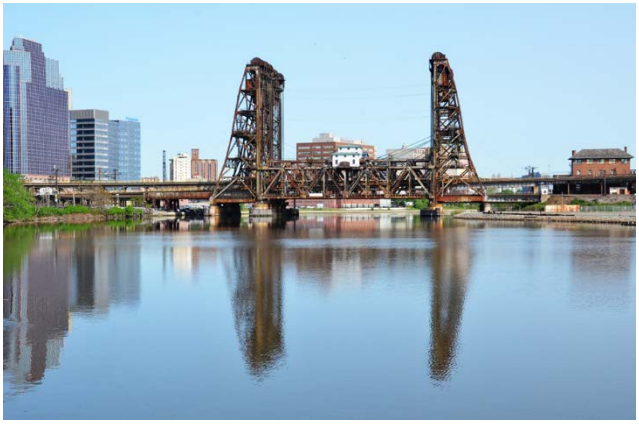

IMAGE: Dock Brigde (Courtesy of Matt Gosser)

Approximately 39% of Newark households do not have access to a private vehicle. For one-person household, this percentage rises to 55%. Therefore, buses play an important role in transporting 24,000 residents or 74 percent of workers to jobs and subway stations. Of those workers taking public transportation, almost 71 percent earned less than the $35,000 annually.

Newark is one of the most densely populated and park-poor urban centers in the United States. Newark has only 2.9 acres of parks per 1,000 residents. That acreage rate is two and a half times below the average for comparable cities. Over half of Newark's children do not have any significant green space within a quarter-mile of their homes. Newark has two parks designed by the celebrated 19th century landscape architect Frederick Law Olmstead: Weequahic Park and Branch Brook Park.

IMAGE: Branch Brook Park (Courtesy of Matt Gosser)

Psychological trauma may be initiated and reinforced by social and environmental factors; factors that are wide-spread in Newark. Poverty, discrimination, poor physical health, lower health literacy, crime and violence rates, air and water pollution, and a lack green space may contribute to the self-rated 'poor' health and negative 'quality of life' Newark residents experience. This may make Newark residents more vulnerable to trauma exposures and their impact. Symptoms of psychological trauma are many. With approximately 16 percent of Newark residents reporting 'not good' mental health, this issue is a vital one to address.

Social Determinants of Health in Newark

Social determinant	Underlying factors of influence	Factors in Newark
Economic stability	Unemployment, housing insecurity, food insecurity, and poverty	Unemployment rate 18.4% Child food insecurity 25% Below federal poverty line 30% Children in low income household 69% Children in extreme poverty 18%
Education	Early childhood education and development, high school graduation, language and literacy, and higher education enrollment.	High school completion 35% Students not proficient on standardized literacy tests 56% 9th grade education or less 14%
Health and Healthcare	Access to health care, access to primary care, and health literacy	Health insurance 75% Few ambulatory services
Neighborhood and built environment	Access to healthy foods, quality of housing, crime and violence, and environmental conditions	Old housing stock Low home ownership Violent crime is 3X national rate Do not feel safe in the streets or public spaces 50% Three active SuperFund sites Poor air quality Acres of parks/1000 residents 2.9
Social and community context	Social cohesion, civic participation, discrimination, and incarceration	Mostly minority community Residential segregation

Newark: A Work in Progress

Institutions and community members have begun to address psychological trauma in Newark by considering social and environmental factors. Background information on psychological trauma may be found in the **Side Bar** that follows the case study references. Symptoms of emotional/psychological trauma may be found above in the **TABLE: Emotional/Psychological Trauma Symptoms.**

The Greater Newark Healthcare Coalition (http://greaternewarkhcc.org/) is working to establish care coordination, trauma screening and treatment, professional development, and data integration practices. The city of Newark through its Department of Health and Community Wellness (https://www.newarknj.gov/departments/healthcommunitywellness) operates a Federally Qualified Health Center. Besides primary health care, the clinics offer dental services, environmental health services, sexually transmitted infection services, and hospital diversion services. The Rutgers School of Nursing provides health and wellness services to high risk/high need areas in Newark through its mobile health van (http://nursing.rutgers.edu/jhchc/) and the FOCUS federally qualified health care clinic (http://nursing.rutgers.edu/focus/). Rutgers School of Nursing faculty are investigating the use of mindfulness and yoga training with preschoolers in a school setting. University Hospital in Newark offers services post discharge to assist patients and families who are physical trauma survivors to address social factors and has begun a hospital-based Violence Prevention Program. The Sanar Wellness Institute addresses gender-based violence. Equal Justice USA (http://ejusa.org/) is working with police and community members in Newark leading trainings on "Trauma Informed Responses to Violence: Newark Police/Community Training Initiative." The Center on Law, Inequality & Metropolitan Equity hosted a Trauma-Informed Care Roundtable at the Rutgers School of Law-Newark, co-sponsored with the New Jersey Attorney General's Office. Newark's Office of Planning, Zoning & Sustainability is working to make the city a healthier and greener place including efforts targeting public art, riverfront revival, and superfund sites remediation.

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Vignette 1: Jack

Jack is a 33-year-old, unauthorized immigrant, born in Brazil. Jack lives in Newark's Ironbound section. Jack is from a religious family; his father is a church pastor living in Brazil. Jack is not particularly religious and came to think of himself as the "black sheep" of the family. Jack started drinking alcohol in his early 20s, after he moved to the United States, at that time he was drinking socially and only during the weekends. Over time, his alcohol intake increased due to work-related pressures and financial stress. He went from a six-pack of beer on a Friday or Saturday night to a twelve-pack. Eventually he started drinking during the week as well as on weekends and soon progressed to cocaine use. The cocaine use led to insomnia and other health-related issues. Jack eventually lost his business: not only could he not run the business because he was always high, but his cocaine habit put additional stress on his worsening financial situation, which eventually meant he couldn't pay his business or personal bills.

Through-out this time, Jack tended to downplay and minimize his alcohol and drug issues. He avoided talking about them and even thinking about them.

It was at the height of his alcohol and drug use that Jack found himself frequently going out with a similarly rough crowd of acquaintances. One evening, when he was hanging out with friends in Newark, someone from another group erroneously accused Jack of being an informant. As retribution, he shot Jack in the hip and foot using an automatic weapon. As Jack and his buddies were under the influence of illegal drugs when he was shot, his friends dragged his heavily bleeding body into the car and dropped him off at a nearby gas station and left. The gas station attendant called for an ambulance due to Jack's heavy bleeding.

Once at the hospital, the bullets in his hip were successfully removed, but one that went into his foot was not, causing an infection that led to a three-week hospital stay. Upon discharge, Jack went to his sister's home to convalesce. To protect him, his sister hid all the alcohol she had; however, he found a bottle of liquor in the basement. Under the influence of alcohol, he stole his sister's car, was involved in an accident that severely damaged the car and led to a "driving under the influence" (DUI) arrest.

After the shooting and the auto accident, Jack realized that he was in trouble, nonetheless, he continued drinking until his court date. During this period, his wife, to whom he had been married since he was 19, divorced him due to the alcohol use, drug use, and related financial woes. Jack was referred by the court to New Jersey's Intoxicated Driver Resource Center (IDRC) for education and assessment for substance abuse treatment. IDRC then referred Jack to a local mental health agency for substance abuse treatment.

Jack has been abstinent from both drugs and alcohol for just over a year as evidenced by urine testing. Although Jack doesn't really want to go to counselling, he has established a relationship with his therapist, is opening up more, and making notable progress. In addition to therapy, he has started going to church, engages in positive self-care, exercises, and works full time. He describes his abstinence as a religious awakening.

Jack did not, initially, report the shooting to the police, in part because he was an undocumented immigrant and fearful of deportation, but also because he suspected that his assailant was affiliated with a gang (this assumption is based on the type of automatic weapon used). After time to think it through, Jack did eventually report the shooting, under the promise of a U-Visa. Even with this protection, the shooting and the fear of revenge continue to haunt him; the shooting continues to preoccupy his thoughts. He is anxious and has isolated himself. He stopped attending church services for fear of running into the "wrong" people. He was living with a friend, but routinely leaves town daily for his safety. He does not want to return to Brazil because he doesn't have a life there (as he has been in United States since he was 18), so he's thinking about relocating out of state.

In therapy, Jack is continuing to build his coping skills, reinforcing the positive steps he has made, and is working on understanding the traumatic events in his life. During therapy, he recognized that his father had a history of substance abuse problems, helping him recognize that all humans have failings, and that he really wasn't an exception in his family. Jack was encouraged to see a primary care clinician to address his sleep as well as anxiety issues. Jack had previously professed a ''love a water", so he was encouraged to use the community pool on a regular basis as well as walk by the river.

Vignette 2: Samuél

Samuel is a 33-year-old Hispanic male who lives in Newark. When you first meet him, Samuel puts on a brash persona that melts away as he begins to feel more comfortable. The brashness appears to be a cover up for his feelings of inadequacy and loneliness. Samuel was sexually abused as a child, an experience that he kept secret from his family for fear that they couldn't "handle it". He didn't feel sufficiently supported within his family to discuss this experience of rape by an adult female, and the stigma surrounding such an experience. For years, he blamed himself for the incident; only with therapy did he start to redirect responsibility to his perpetrator. He still carries shame and embarrassment and continues to experience panic attacks and ongoing self-blame.

Samuel grew up in a home where smoking was normalized: his mother was a smoker, his dad was a smoker who quit, and his grandmother smoked and died from emphysema. Samuel has smoked cigarettes since he was a teenager, until recently he was a heavy smoker.

Samuel, started using oxycodone and valium when he was 17 years old after they were prescribed for a back injury. When the prescriptions for opioids ran out, he purchased them illegally. He eventually started adding marijuana and ecstasy to his opioid habit.

Samuel is overweight and has been for most of his life. Samuel has had difficulties with sleep much of his life and on-and-off suffers from nightmares.

At age 30, Samuel was in a car accident again injuring his back and eventually causing the development of syringomyelia. Although he is in medical care for the syringomyelia, this condition led to oxycodone use/abuse and then heroin use, as heroin is cheaper to buy on the streets than is oxycodone. He denies using heroin intravenously, stating that he takes it via intranasal only.

Samuel was imprisoned for 18 months for possession of controlled dangerous substances, specifically opioids. After his release from prison, he spent 90 days in a reentry program. He then entered an intensive outpatient drug treatment program that was supposed to last 6 months, but he dropped out after his counselor left the program to take another job.

Samuel was referred to a local mental health agency via the New Jersey Division of Mental Health and Addiction Services (DMHAS) hotline. Although he was motivated to seek treatment, this internal motivation was externally reinforced by the fact that he was still on probation and required by law to stay in treatment. Samuel completed the "traumatic assessment questionnaire for adults" and with time verbalized his childhood traumatic event exposures. With sensitive support by his therapist, Samuel has worked to see himself less through a shame-based lens using techniques like talking, journaling, and mindfulness.

Samuel has been drug-free for much of the last 6 months, with only one "dirty" urine test. He is working on cutting down his cigarette smoking. He has worked full time for over a year earning a good salary. Samuel states he is committed to getting his life back together. He feels a sense of hope for the future, that is encouraged and supported by his mental health therapist. Samuel has made an appointment with a primary care provider to address his weight issue and to discuss medication to address his cigarette smoking. In addition, Samuel and two co-workers have agreed to walk for a half hour each day during their lunch break.

Vignette 3: Dinah

Dinah is a 60-year old U.S. born African American female who has lived in Newark, New Jersey for most of her life. She identifies as heterosexual. Her nurturing personality and engaging speaking style become apparent once you get to know her. As a six-year old girl, Dinah was sexually abused by her older brother. The abuse continued until she was 13, and during this period, her brother sexually abused Dinah's younger sisters as well. This experience inspired a tremendous sense of guilt: because Dinah never revealed the abuse, she believes that she failed to protect her sisters. She began self-medicating with cocaine as a youth because of her unresolved guilt at not protecting her sisters. Eventually, she stopped using cocaine, but she returned to self-medication after she was prescribed oxycodone to help her manage chronic pain related to Lyme disease, sciatica, and migraines. After starting the prescription, she found that she couldn't stop, and when her prescription ran out, she began buying oxycodone on the street for $20 a pill.

Dinah completed high school. As a young woman, Dinah worked a series of part time jobs. She never married, but she did enter into several intimate relationships. In one of her partnerships, she experienced domestic abuse.

Eventually, Dinah was diagnosed with "bipolar depression" and given prescriptions for Xanax, Lexapro, and Seroquel to help treat her symptoms. She began receiving payments through the Supplemental Security Income (SSI) program. However, the costs of Dinah's oxycodone addiction became so great that she could no longer afford her prescriptions and could not pay her rent.

Eventually, Dinah found her herself homeless. While living on the streets, she began squatting in abandoned apartments and switched from taking oxycodone pills to sniffing heroin. Her friends and acquaintances also used drugs, and many of them were homeless. As a nurturer and caretaker, Dinah looked after her friends and was expected to share drugs with them. When she was unable to do so, her friends isolated her. Once, a male friend assaulted her when she revealed that she had no drugs to share. She did not report the assault. Instead, she moved into another abandoned building. During this time, Dinah was unable to reach out to her family

for help. Although her sisters lived in nearby Elizabeth, she had no contact with them and she struggled with extreme social isolation and poverty. Dinah depended on a soup kitchen in Elizabeth to eat. Dinah remained homeless for a year and was eventually referred to a local mental health agency.

The mental health agency offered Dinah weekly counseling sessions and referred her to a multiservice agency offering housing, case management, and psychiatric treatment. Dinah tested HIV negative. Dinah accessed addiction treatment through an area Hospital, where she had received emergency department care in the past. However, working with healthcare providers was difficult for her. Dinah did not feel comfortable with most healthcare providers. She felt that they looked down on her because she was homeless. She did not feel respected by them, and in general, she felt ignored when she interacted with clinicians. For example, Dinah reported that her psychiatrist did not make eye contact with her during her brief 5-minute appointments. Instead, he focused on writing her prescription renewals during their visits and asking quick, general questions. Yet, despite her ambivalence about seeking healthcare, Dinah began a 3-month intensive outpatient program at an area hospital for co-occurring addiction and mental health issues. During Dinah's treatment, she relapsed and began using heroin again. In the last week of the program, she experienced a drug overdose. A sympathetic cousin found her and helped save her life. Despite this experience, she was discharged from the outpatient substance abuse treatment program.

Two months ago, Dinah moved in with an elderly aunt and became her primary caregiver. She stopped using heroin for a while, but soon found that the pressures of this caregiving responsibility weighed heavily upon her. Her aunt's immediate family did not express any appreciation for her efforts, believing that she owed her aunt day-to-day care in exchange for a place to stay. This lack of appreciation, together with her unresolved feelings of guilt about failing to protect her sisters, made coping difficult. The unaddressed pain of her three chronic medical conditions (i.e., Lyme's disease, sciatica, and migraines) added to her stress level, and eventually, she relapsed and began using heroin again.

Despite the relapse, Dinah has continued to attend counseling sessions at the mental health agency. Recently, she joined a relationship trauma repair group there. The trauma repair group uses a “Seeking Safety’ counseling model focused on the present that helps individuals attain safety from trauma and/or substance abuse. The group also uses peer connection and sponsorship techniques. The mental health agency has helped her apply for access to medical transportation. In the meantime, the mental health agency provided her with bus passes to assist her in accessing needed resources.

Dinah still has no regular source of primary medical care. She goes to the emergency department at the nearest hospital for emergent medical issues. Her Lyme disease, sciatica, and migraines remain untreated. Her therapist continues to encourage Dinah to make an appointment with a primary care clinician while working to build her trust in medical professionals and institutions. The mental health agency is working to secure on-site primary health care services through a partnership with a local university and agency staff believe this may provide a means through which Dinah will eventually access primary care.

Vignette 4: Paloma

Paloma is a 36-year old Hispanic female. She was born in the Dominican Republic and moved to the United States approximately 10 years ago. Before moving to Newark, Paloma lived in Bronx, New York. In the Dominican Republic, Paloma and her two siblings were raised by a single mother. Paloma was the middle child, and her birth was unplanned. Because of this, she felt that her mother treated her differently than she treated her siblings. Paloma remembers her childhood as a time of neglect and abandonment, and she retains a tremendous sense of anger about this.

As an adult, Paloma has experienced few extended periods of consistent employment. She never finished high school, leaving after the 9th grade. As a young woman, she worked at a restaurant, and then at a laundromat before becoming pregnant. Her partner was the father of her first two children, and the two of them stayed together until he died unexpectedly. Afterwards, Paloma began living out a cyclical pattern that alternated between living in stable housing and becoming homeless. At the beginning of the cycle, she moved in with a new partner and stayed with him for about a year, at which time the relationship ended and she and her children were evicted without the ability to pay rent on their own. There was one period in which she received $600 in food stamps and cash and one of baby's fathers contributed to her expenses, but this did not last.

Today, Paloma has seven children and is eight months pregnant. The oldest two children are 21 and 19 years old. Her 17-year-old son has problems with kleptomania. Recently, her 15-year-old daughter said that she wants to kill herself. She made this statement in school, and the school referred the child, who lives in the custody of an aunt, to outside psychological care. Paloma sees her daughter's statement as a kind of temper tantrum, remarking, "All children make those of kinds of comments." Paloma also has an 8-year-old and her youngest child is 2. Two or three months ago, Paloma was told that the youngest needs speech therapy and may have fetal alcohol syndrome. Paloma reports that she only had one glass of wine two months into her pregnancy: "Who doesn't have beer or wine when they are pregnant?" There is another child as well, but Paloma does not share any further information about that child.

Paloma has repeatedly interacted with child protection agencies concerning the custody of her children and her use of alcohol. Her drinking has also led to her estrangement from family. Her mother lives in nearby Elizabeth, but their relationship is strained. Paloma's relatives have taken custody of two of her children because of her drinking issues. However, Paloma does not think she has a problem. She believes that everyone drinks alcohol, and her friends and acquaintances reinforce this belief.

Recently, Paloma was referred to a local mental health agency by the Department of Child Protection and Permanency (DCPP). This happened when two of her older children called DCPP when they realized that Paloma was leaving their younger siblings alone in a hotel for extended periods. Paloma and her two youngest children had been without a permanent place to live for some time when this occurred. The family had been staying at a hotel together, but Paloma has been leaving the children alone early in the day to go out and work: "I went out because I needed to find the money". Paloma was making her living as a sex worker. When DCPP found the children, they appeared to be malnourished and there was little food for them in the hotel room. They were immediately taken to an area hospital child abuse program for medical evaluation.

Paloma did not go to the hospital to see her children until the next day, and when she arrived, she was under the influence of alcohol. Consequently, DCPP referred her to a local mental health agency. At her first visit to the mental health agency, Paloma expressed a great deal of anger at the DCPP. She had been involved with the New Jersey agency before, and this was not the first time that allegations of child neglect had been made against her. She also had a comparable case open in New York, levied for similar reasons. Paloma currently does not have custody of any of her children. But she has asserted that in her home country, her drinking patterns are considered normal: "Everyone drinks and there is nothing wrong with that!" After this incident, DCPP asked her to take a 120-question mental health assessment. Paloma did not fully understand the questions, and she answered them as best she could. When she was referred to a psychologist for mental health treatment afterwards, she protested that this was not needed. However, her mental health counselor agreed that with the findings and that she needs the support.

When Paloma lost custody of her children, she lost all her benefits, including Medicaid. This occurrence, along with her struggles with child protective services, made her angry and led her to believe that everyone was set against her. Without Medicaid, she could not see a doctor and she had no prenatal care. Initially, she tried to reapply for Medicaid on her own, but when she was asked for proof of an address, she could not provide it. She was moving from house to house, staying with friends and acquaintances. After her referral to a local mental health agency, a counselor helped her reapply for Medicaid, and eventually, her benefits were restored. Then the agency began connecting her to additional resources. First, she was referred to a doctor at University Hospital for OB/GYN care, and then she was given a voucher for a homeless shelter in Newark, NJ that could offer her short-term housing while she looked for a stable place in which to live with her children.

At first, she did not attend mental health counseling sessions consistently and stayed silent when she did come. But over time, she began building trust with her counselor and started attending more consistently. She came to both individual and group sessions and graduated from the program. Afterwards, she continued coming to the group and asked her counselor to attend her meetings with DCPP via telephone. At one point, she confided that she was feeling ambivalent about retaining custody of her soon-to-be-born child. She felt that the pregnancy was a barrier to obtaining custody of her other children because she could not work while pregnant, and therefore could not afford an apartment. Without a stable home, she couldn't regain custody of her children

Two weeks ago, Paloma told her counselor that she was being transferred to a new shelter in which her baby, once born, could stay with her. She is now in the process of obtaining housing assistance. She would like to become a certified home health aide and hopes to join a training program at Essex County College. Right now, she is surviving on food stamps. She has completed two parenting classes---one in Newark, NJ and one in New York. She has no regular source of primary care and gets her OB/GYN care at University Hospital. She has been tested for HIV and she is negative. She does not want to have any more children. Her counselor has referred her to Planned Parenthood and encouraged to go and explore her birth control options.

Paloma continues to go to court hearings to try and regain custody of her lost children, but the case has been open too long and the court is considering giving permanent custody to those who have the children right now. Paloma has been asked if there is anyone in the Dominican Republic who can take custody of all her children at once. She has provided some possible names. This would allow the children to stay together. It is unclear if Paloma will be able to find employment and stable housing and regain custody of her children. She keeps coming to group meetings at the local mental health agency. Her counselor recognizes that pregnancy may be a time when women are more open to positive change. She continues to encourage Paloma and offer her hope and offer support for managing present day challenges.

Concrete Resources for Individuals and Families

Resource	More Information
Energy Assistance Program	http://www.nj.gov/dca/divisions/dhcr/offices/energy.html
Federally Qualified Health Centers	https://www.cms.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHC-Center.html
Head Start and Early Head Start	https://www.acf.hhs.gov/ohs
Homelessness Prevention	http://www.nj.gov/dca/divisions/dhcr/offices/hprp.html
HUD Housing Choice Vouchers	https://www.benefits.gov/benefits/benefit-details/710
Medicaid	https://www.medicaid.gov/
Supplemental Nutrition Assistance Program (SNAP)	https://www.fns.usda.gov/snap/supplemental-nutrition-assistance-program-snap
Temporary Assistance to Needy Families (TANF)	https://www.acf.hhs.gov/ofa/programs/tanf/about
Women Infants and Children (WIC)	https://www.fns.usda.gov/wic/women-infants-and-children-wic