

Surveying Services and Programs in WNY Engaging Women and Children Who Have Experienced Trauma



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Executive Summary

Executive Summary

The Health Foundation of Western and Central New York (HFWCNY) is focused on young children impacted by poverty five and under to ensure they are emotionally, socially and physically ready to enter kindergarten. Research informs that trauma and toxic stress are exposures that can produce environmental and social risks that can negatively impact a child's ability to thrive in early childhood.

In an effort to better understand current literature and what services and supports are available for women and their children specific to trauma and adverse experiences, the HFWCNY commissioned a report to provide a literature review, a survey of services and programs across the 8 counties of WNY, and an overview of potential recommendations.

Included in this report is a synthesis of the literature regarding the effects of trauma and its treatment in the perinatal period and during early childhood, an overview of findings from the comprehensive survey/scan of community trauma resources in the eight county WNY region, a discussion of the findings, and a presentation of implications and recommendations.



Review of the Literature

Living in poverty and experiencing trauma are both influential risk factors for young families. **There are approximately 15 million children living in families experiencing poverty in the US.** This represents **21% of all US children.** Black, Native, and Hispanic children are **twice as likely** to live with chronic scarcity as White children. **In Western NY, rates are even higher, with over 30% of children under the age of 5 living in poverty.** Poverty presents challenges such as food insecurity, inadequate housing, decrements in school readiness and educational attainment, and a lack of preventative health and dental care.

While anyone may experience trauma, poverty and the roots of psychological trauma are strongly correlated. Although statistics vary by region and country, a conservative estimate is that **one quarter of all adults has been physically abused in childhood,** and that **1 in 5 women, and 1 in 13 men have experienced childhood sexual abuse.** Many are also victims of emotional/psychological abuse, and **1 in 5 women experience adult sexual assault or dating violence.**

The effects of trauma have now been well characterized for risk during the childbearing year, and for early childhood. These include posttraumatic stress triggered by pregnancy and maternity care, depression, increase in substance use, decrements in birth weight and gestational age, pregnancy and birth complications, increases in postpartum depression and posttraumatic stress, impairments in early mother/infant bonding, and insecure or compromised mother/infant attachments

and interactions. Infant feeding practices may also be adversely affected, as well as sleep routines, and engagement in well-child visits, vaccinations, and safety practices. Posttraumatic stress and depression are also likely contributors to maternal suicide.

Chronic stress, either from chronic scarcity, or traumatic exposure, can have long-lasting effects for both mother and baby. Stress is a contributory factor to the development of diabetes, obesity, and hypertension in women, patterns of which may emerge during pregnancy

in the form of gestational diabetes and preeclampsia/gestational hypertension. Mothers of color are at increased risk for developing these conditions, and infants of mothers with such risk are also at risk for similar conditions across their lifespan. In the short term, chronic scarcity and traumatic sequelae are likely contributors to risk for delayed development across several domains, all of which contribute to school readiness and eventual educational attainment.

In short, poverty and trauma may be seen as concurrent cycles of risk and vulnerability—both chipping away at the health and wellbeing of families and at a child's readiness for school and lifelong success.





Agency Scan/Interview Results

A comprehensive inventory of trauma related services, supports, and programs within the 8 counties in WNY were undertaken by a small team of consultants. The team synthesized data from 68 agencies/programs.

Overall, there appeared to be no uniform or specific accounting for mothers and babies within agency client populations, although many agencies offered that typically their families were:

› **Living in poverty**

› **From single parent households**

› **Dealing with crises** like substance abuse, domestic violence, and child abuse

› **May not enter services until such crises come to the attention of child protection or law enforcement**

Agencies were asked about their program's definition of trauma and any engagement with trauma-informed care. Overall synthesis of their responses indicated that:

› By and large, **agencies do not have a universal working definition of trauma**

› Trauma is often narrowly defined as accordant with the services the agency provides

› Many assume that the effects of trauma in the lives of mothers and babies centers on domestic violence exclusively

› Many agencies have sought some training on trauma and/or trauma-informed care; however, **few defined their agencies as actually being “trauma-informed”**

› Several expressed concern about **not having access to trauma-specific interventions and training** on how to apply trauma-informed understandings. This suggests that many may subsequently feel “all dressed up with nowhere to go.”



All of the agencies interviewed were asked to provide information on the following areas:

Trauma services for mother & baby. Although many services are available for women and children in general across the eight counties, including early childhood education, child protective services, substance use treatments, and parenting classes and supports, these are not specifically focused on trauma prevention or recovery. Importantly, we found **no evidence that the available trauma-specific offerings were specifically targeted to mothers and children under the age of five.**

Funding. Agencies in Western and Central New York who provide services to mothers and their babies are spending a significant amount of time and effort to procure funding. They are reliant on a multitude of funding streams including federal, state, county, and local sources. Some agencies are partnering with other agencies when possible to secure funding.

Assessment, evaluation and outcomes. Overall, it appears that assessment for trauma is not routine, although the Adverse Childhood Experiences screening tool is being used by some agencies. Outcomes related to reducing the burden of trauma for mothers and young babies/toddlers was not available. Evaluation typically centers on client tracking and satisfaction surveys.

Partnering. Those who focus on trauma already are more likely to know about other trauma-related services and maintain partnering relationships, while those agencies not already focused on trauma and its treatment appear to rely on less formal referral resources. Overall, trauma-related and childbearing-specific referral streams are limited. Referrals for trauma-related services are generally not focused on the perinatal period.



Current challenges. **Funding** is the most frequently cited concern, which is putting stress on service provision. Agencies express a desire for **more inter-professional collaboration, more support to translate trauma-informed care into practice, and an increase in trauma services.** **Stigma** is cited as a challenge in the provision and uptake of services. Agencies also express their impression that the **perinatal period and infancy appear to be less of a current focus** in terms of funding availability and often report being overwhelmed at times with the complexity of need experienced by clients (Ex. Simultaneous concerns with safe housing, transportation, substance use, and mental health).



Pressing needs. These are far ranging and include:

› **Prevention education**

› **Treatment gaps** exist for services for single mothers, infants, toddlers, refugee mothers, court-involved families.

› There is a perception that **care is fractured and uncoordinated** in relation to trauma.

› There is a **lack of access** for early childcare and parenting support.

› There are **limitations in access to substance use treatment**.

› **Housing and transportation** are cited as particularly pressing issues.

› **Provision of care is often stigmatizing and has the effect of denying care to those who most need it.**

› There is a need for a **greater recognition among care providers as to cycles of violence and vulnerability.**



Discussion and Recommendations

Many agencies are working hard in Western New York to provide trauma-responsive services to mothers and babies. Several have sought training for their staff in trauma-informed care, and are utilizing evidence-based interventions for the treatment of trauma in general. Mothers and infants who are in crisis, either due to domestic violence, rape, substance use, and child protection concerns are coming to the attention of service providers, who are reacting to the crises and providing appropriate interventions and treatments. However, there appears to be little in the way of specific attention to the trauma-related needs distinct to the childbearing year and early mothering epochs. This is unfortunate since pregnancy presents an opportune time for case-finding and treatment, considering the stepped-up level of engagement in maternity care and supportive services. It is advisable that agencies capitalize on this opportunity by moving “upstream” in order to move beyond crisis reaction and be proactive in addressing traumatic sequelae of childbearing women. Moving upstream in a proactive way suggests that:

- **Agencies need to develop methodology to account for pregnant and postpartum women in their client populations.**
- **Clinicians require more education** regarding the extent of trauma and its effects on the childbearing year and the concurrent effects of poverty and stress - beyond current crisis situations.
- **There is a need for universal screening** for trauma for childbearing women, as well as developing better methods for tracking on outcomes and evaluating trauma services.
- **Screening, referral, and coordination of mental health services** in an effective way would be better accomplished within integrated care settings
- **Universal interventions that provide critical support for mothers and babies** should be continued and strengthened. These include perinatal home-visiting programs, parent education and support, childcare, and early childhood education. One universal (and also trauma-specific) intervention is infant mental health; to date such services are only very minimally available in the state of NY.
- **Trauma-specific and perinatally-focused interventions should be developed, adopted, and scaled-up for delivery during the perinatal period.**
- Concurrently, **practical needs** due to chronic scarcity must be addressed, including transportation and housing.

All of these proactive responses will require adequate funding and supportive policies to power change upstream.

Other “big picture” considerations are the need to address the institutionalized stigma experienced by those living in circumstances of poverty, and to call out the structural racism inherent in the river’s waters.

The data presented here are from the perspective of the care providers. What these data do not tell us is how trauma, poverty, and trauma-informed care and services are experienced by the women themselves who are being served by agencies. How would they define trauma and its role in their lives as mothers? For women who are themselves in the water—what do they see as the most helpful interventions and supports for themselves and their babies? What do they think will buoy them, or help them to swim?

The information shared above coupled with the past and current investments undertaken by the Foundation were incorporated in the development of the Co-Creating Well-Being: Supporting Children and Families Through Trauma project.





Literature Review

Statement of Purpose

The purpose of this report is to inform the Health Foundation of Western and Central New York (HFWCNY) about services and programs currently available across Western New York directed at engaging women and children who have experienced trauma in an effort to inform future funding directions. Included in this report is a review of the literature of the effects of trauma and its treatment, and a comprehensive community trauma resource inventory of the eight counties of Western New York. A synthesis of our findings highlight promising programs and/or services, identifies gaps in existing programs and/or services, and makes recommendations for funding directions.



Poverty, Trauma, and School Readiness— A Focus on Mothers and Babies 0 to 5

Poverty

The HFWCNY is focused, in part, on assisting families in accessing the care, information, and tools they need so that children are physically, socially, intellectually, and emotionally ready for school. HFWCNY has long acknowledged the deleterious effects of circumstances of poverty on families, and in particular on the growth and development of children.

It is important to flesh out what we mean when using the term poverty. Borrowing from the discussion initiated by [Ideas42](#) white paper authors Daminger, Hayes, Barrows, & Wright (2015) in their white paper titled, *“Poverty interrupted: Applying behavioral science to the context of chronic scarcity,”* poverty is far more complex a phenomenon than financial hardship. Poverty is a set of conditions that affect a family’s overall health and well-being; infringing on education, skills, relationships, networks of support, and physical and emotional health. Poverty is not a result of

SOCIAL DETERMINANTS OF HEALTH

According to the World Health Organization (2017), “the social determinants of health (SDH) are the conditions, in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems.”

the character of the person living in poverty, it is the social, political, and economic environment in which a person lives, works, plays, and loves that strains one’s capacity (See Social Determinants of Health).

Ideas42 authors Daminger, Hayes, Barrows, & Wright (2015) reframe the conversation around poverty, defining poverty as chronic scarcity and delving into the ways in which such scarcity shapes behaviors. To focus on the predictable ways in which individuals cope with and maneuver through such

scarcity helps to shift the conversation toward changing the environment that maintains such paucity and away from the moral judgment often associated with those deemed “poor”. This framework of poverty in terms of chronic scarcity also leaves ample room for the acknowledgement of the capacity of individuals, families, and communities to possess and engage in resilience—defining people by their multidimensionality and not simply the circumstances in which they live.

Circumstances of chronic scarcity are ubiquitous, with an estimated 43.1 million Americans living in poverty in 2015 (Proctor, Semega, & Kollar, 2016). According to



FEDERAL POVERTY LEVEL (FPL)

The most common measure used to determine eligibility for government assistance, such as Medicaid, is a measure of income referred to as the federal poverty level (FPL), which is determined by the Department of Health and Human Services.

The 2017 FPL income numbers are as follows:

\$12,060 for individuals

\$16,240 for a family of 2

\$20,420 for a family of 3

\$24,600 for a family of 4

authors Jiang, Granja, & Koball, at the [National Center for Children in Poverty \(2017\)](#), 21% of all children, approximately 15 million, are living in families with incomes below the federal poverty line (FPL); 2.6 million of those children are under the age of 3. Furthermore, Black, Native, and Hispanic children are far more likely to live in low-income households—69% of Black infants and toddlers, 64% of Native infants and toddlers, and 63% of Hispanic infants and toddlers compared to 33% of White infants and toddlers (Jiang, Granja, & Koball, 2017).

IN NEW YORK STATE, 10% OF WHITES EXPERIENCE POVERTY, 22% OF BLACKS, AND 23% OF HISPANICS

*The Henry J. Kaiser Family Foundation
State Health Facts*

Circumstances of poverty present numerous risks for developing families and specific challenges stand in the way of health for young children, including a family's "race"/ethnicity (Weinick & Krauss, 2001), food insecurity (Cook et al., 2004), poor housing conditions (Martens et al., 2014; Krieger & Higgins, 2002), and lack of preventative health and dental health care (Newacheck, Hughes, Hung, Wong, & Stoddard, 2000; Guarnizo-Herreño & Wehby, 2012).

Not only is a child's health infringed upon by the circumstances of poverty, a child's psychological wellbeing may also be compromised. Circumstances of poverty and the roots of psychological trauma, such as child maltreatment are strongly correlated (Sedlak, Mettenburg, Basena, Peta, McPherson, & Greene, (2010). In 2005, an estimated 1,250,000 children experienced maltreatment; 44% of which experienced abuse, while 61% experienced neglect (Sedlak et al, 2010). Much like the statistics of poverty, Sedlak et al. (2010) reported an overall greater rate of maltreatment in all forms among Black children. This by no means suggests that one's race determines his or her risk of perpetrating violence or of victimization, rather, in the context of chronic scarcity, it calls into question circumstances of poverty, the resulting levels of stress and strain on a families social and emotional capacities to cope, and highlights the disproportionate number of Black and Brown families living in poverty.



Trauma

Compounding the effects of poverty are the effects of intergenerational cycles of violence and psychiatric vulnerability. We are beginning to understand that adverse or traumatic experiences in childhood and its sequelae have a profound effect on health and behavioral health for young families. Healing these effects will necessitate not only an integrated understanding of trauma and its effects linked to appropriate interventions targeted at affected individuals, but will also require environmental, social, economic, and policy interventions at multiple levels in order to effect lasting change (Torchalla, Linden, Strehlau, Neilson, & Krausz, 2016).

Many people will experience trauma in their lifetime. This may include direct exposure to actual or threatened death, serious injury, sexual violence, or prolonged/insidious stressors, as well as indirect exposures such as learning that such traumas have happened to a loved one, or experiencing repeated or extreme exposures to details of such traumas (American Psychiatric Association, 2013).

As stated above, unfortunately, many children are exposed to trauma early in life and are victims of child maltreatment. The World Health Organization defines child maltreatment broadly:

“Child maltreatment, sometimes referred to as child abuse and neglect, includes all forms of physical and emotional ill-treatment, sexual abuse, neglect, and exploitation that results in actual or potential harm to the child’s health, development or dignity. Within this broad definition, five subtypes can be distinguished—physical abuse; sexual abuse; neglect and negligent treatment; emotional abuse; and exploitation” (World Health Organization [WHO], 2014).

Across the world, it is estimated that **one quarter of all adults have been physically abused in childhood, and that 1 in 5 women and 1 in 13 men have experienced sexual abuse as children** (WHO, 2014). As previously mentioned, many children are also subject to emotional/psychological abuse, and many are neglected. Maltreatment is also experienced in adulthood, particularly by women: **1 in 5 women report sexual assault as adults** (Elliot, Mok, & Briere, 2004), and **1 in 5 report severe physical violence** in dating relationships or intimate partnerships (Centers for Disease Control and Prevention, 2014).



Research shows that early experiences with trauma and adversity have long-lasting and profound effects on the lives of affected individuals. The landmark [Adverse Childhood Experiences \(ACE\) study](#) reported the findings of over 13,000 individuals and the effects of their experiences of physical, sexual, and/



or emotional abuse in childhood, as well as physical and emotional neglect, violent treatment of one's mother, household substance abuse and mental illness, parental separation/divorce, and having an incarcerated household member. They found a dose-response pattern of vulnerability to a variety of adult health conditions based on increased experiences of childhood maltreatment; the greater the number of adverse experiences in childhood, the greater the likelihood of adverse health outcomes in adulthood including alcoholism, drug abuse, suicide attempt, smoking, and heart disease (Felitti et al., 1998). The ACE study has effectively demonstrated how experiences in early childhood can have a profound effect on the course of an individual's health and development.

Following the ACE study there has been a surge of research looking for the mechanisms by which adverse childhood experiences translate into diminished health and/or mental health. One ever-growing avenue of investigation into how we embody psychological trauma is that of a stress mechanism. A stress response is a natural, strategic, and protective response to perceived threats in one's environment. It is important to understand the stress response as it has a multitude of physiological implications. When the body perceives a threat, psychological or otherwise, there is a physiological response, specifically, a flood of stress hormones released from the hypothalamic-pituitary-adrenal (HPA) axis, which is regulated in part by the hippocampus and involved with the amygdala, among other neuroanatomical structures. Such a flood of stress hormones, namely cortisol and adrenaline, aid the body in responding quickly and efficiently in times of duress and prove functional to the individual. A combination of stress hormones trigger physiologic responses including increased heart rate and breathing, decreased digestive functioning, a surge of glucose from the liver for energy, and suppression of the immune system (McLeoud, 2010). In short, the body works to minimize its efforts that sustain normal functioning to free up its resources to respond to the stressor—fight, flight, or freeze. Additional components of the brain are busy assessing the stressor and making decisions regarding how to respond based upon the information received and processed by our senses and from stored memories, including the autonomic nervous system, which helps to maintain homeostasis (McLeoud, 2010).



Fluctuations in maternal stress hormone functioning in pregnancy are normative and important for fetal growth and development, sustained exposure to high levels of stress hormones have been found to be detrimental (i.e. intrauterine growth restriction) (Rondo, Ferreira, Nogueira, & Ribeiro, 2003; Valsamakis, Kanaka-Gantenbein, Malamatitski-Puchner, & Mastorakos, 2006; Weinstock, 2005;). Stress at any time, including prior to and during pregnancy becomes problematic and is evidenced to



erode the body's immune system if prolonged (McEwen, 1999; Shonkoff, Boyce, & McEwen, 2009; Lu et al, 2003; 2010; Geronimus, 2001; Green & Darity, 2012). Stress is understood by many to cause such degradation through an inflammatory process, resulting from endocrine dysregulation, which is believed to lead to diseases such as hypertension (Black & Garbutt, 2002) cardiovascular disease (Vaziri & Rodriguez-Iturb, 2006), and obesity and diabetes (Wellen & Hotamisligil, 2005). Chronic stress and correlated physiological responses described above are conceptualized as the pressure (or load) on the body's adaptive systems. Many refer to this measure of wear and tear on the body as the "allostatic load" (McEwen & Seeman, 1999; Lu et al, 2003; 2010; Geronimus, 2001; Green & Darity, 2012). Allostatic load is a composite measure of such physiologic markers as blood pressure, heart rate, and cortisol levels. Sustained threats to homeostasis, in the form of allostatic load, is a theorized mechanism for explaining connections between early traumatic experiences (and the responses to these) to long term health and well-being (See Information Highlight).



Intergenerational Patterns of Health: Risk across the lifespan

A common consequence of stress and its harmful erosion of the immune system is a greater likelihood of an individual developing diabetes, obesity (Wellen & Hotamisligil, 2005), or hypertension (Black & Garbutt, 2002). The stress of circumstances of poverty increases the risk of women developing all three of these health outcomes. According to the [Mayo Clinic](#), women living in poverty, particularly women of color, are more likely to experience higher rates of [obesity](#), [diabetes](#), and [hypertension](#), with each individual health outcome acting as risk factor for the other (Ex. obesity is a risk factor for diabetes and hypertension). The same patterns emerge for risk of gestational diabetes (Fujimoto, Samoa, & Wotring, 2013) and preeclampsia/gestational hypertension (Ghosh, Grewal, Mannisto, Mendola, Chen, Xie, & Laughon, 2014).

All of the aforementioned health outcomes are known risk factors for both mom and baby. In short, mothers of color (who are living in circumstances of poverty at a disproportionate rate) are more likely to enter pregnancy with health conditions that may put mom and baby at risk and are more likely to develop such health conditions during and following pregnancy. According to the [National Institute of Diabetes and Digestive and Kidney Diseases \(NIDDK\)](#), a woman with a history of gestational diabetes is 35-60% more likely to develop diabetes in the 10 years following pregnancy. The child of a mother who experiences gestational diabetes is also at greater risk of developing obesity and type 2 diabetes. Similarly, a woman with a history of preeclampsia is nearly three times more likely to develop cardiovascular disease later in life (Bellamy, Casaa, Hingorani, & Williams, 2007). It is imperative to highlight that babies born to mothers in the U.S. who are Black,, mothers who have diabetes/gestational diabetes and/or hypertension/preeclampsia (Madan, Chen, Goodman, Davis, Allan, & Dammann, 2010) are at greater risk to be born preterm and/or of low-birth weight, which in turns increases the child's risk of obesity and diabetes (Crump, Winkelby, Sundquist, & Sunquist, 2011), and hypertension (Hanna, Cnattingguis, Granath, Ludvigsson, & Edstedt Bonamy, 2017) across their lifespan. Such increased risk of poor health outcomes across the life-course for women and children of color fall into an intergenerational pattern—with each generation of future mother's entering into pregnancy with greater risk of poor health outcomes for both her and her child.





Predicated in part on the stress mechanism, another avenue of examination into the neuroanatomical and physiological consequences of adverse childhood is that of intergenerational patterns of trauma. Considering the consequences to health and well-being of adverse childhood experiences described above, for adult women in particular, it begs the question, do such consequences to a mother's health and well-being effect fetal development?

Evidence indicates that perinatal stress does, in fact, influence fetal development (Lu, Kotelchuck, Hogan, Jones, Wright, and Halfon, 2010). As shown in both human and non-human animal studies, perinatal stress increases reactivity to stress of the fetus indicated by neurologic changes, in particular neurochemical receptors. This neuroanatomical response to stress results in an increased sensitivity to stress and an increase in the release of cortisol (stress hormone). Sustained high levels of maternal stress have been associated with premature birth and low birth weight infants (Matthews & Phillips, 2010). In addition, early exposure to perinatal stress and the subsequent programming of the fetal response to stress sets the stage for poor health outcomes such as hypertension and cardiovascular disease for the child across his or her lifespan (Lu et al., 2010). This evidence harkens upon the fetal origins of disease model that looks at health outcomes across the life span as a consequence of circumstances and exposures while in utero, which contributes to a body of literature on social epidemiology, or the genetic embodiment of the social environment (Shonkoff, Boyce, & McEwen, 2009; Kuzawa & Sweet, 2009; Dressler, Oths, & Gravlee, 2005; Barker, 2004; Krieger, 2001; Barker, Osmond, Golding, Kuh, & Wadsworth, 1989).



For more information on stress and early childhood development, watch a video of [Dr. Sarah Enos Watamura's keynote address from the Toxic Stress Summit in 2014](#)

TRAUMA AND BEHAVIOR

*For more information on **trauma and the brain**, view this short video put forth by UNC's School of Social Work's Jordan Institute for Families*



**[TRAUMA & BEHAVIOR
PART 1: "HOW TRAUMA
AFFECTS THE BRAIN"](#)**

When set in the context of intergenerational patterns of trauma, a mother who has a trauma history of her own and who is experiencing significant stress while pregnant, will likely continue to experience high levels of stress in parenting. Perpetual stress in combination with the challenges of caring for an infant, social and environmental factors such as under-resourced neighborhoods or unsafe housing, leave both mother and child at greater risk of adverse experiences, thus perpetuating the cycle.

The timing and nature of such adverse experiences in a child's life have the potential to change the trajectory of his or her brain development. Teicher and Samson (2016) conducted a review of research concerning the neurobiological costs of childhood



neglect and abuse as measured by magnetic resonance imaging (MRI) or positron emission tomography (PET). They conclude that the type of “trauma” determines, in large part, the consequence to the brain; however findings from a spectrum of studies prove inconsistent. However, evidence is emerging that will codify the effects of the uterine environment on fetal neural functional connectivity. For instance, a recent study found that systems-level neural functioning was diminished in fetuses who were subsequently born preterm (Thomason et al., 2017a); these researchers also found that maternal stress was related to fetal neural connectivity (Thomason et al., 2017b). More research in this area is needed, however what is emerging suggests that long term consequences for children begin in the womb.



Evidence is also mounting with regard to structural and functional brain changes associated with childhood maltreatment, as is evidence illuminating the relation to behavioral, learning, and cognitive deficits for children so affected, and the significant costs to individuals, families, and society (Delima, & Vimpani, 2011). It has been estimated that child maltreatment may be responsible for almost a quarter of the overall burden of mental disorders, with economic and social costs on a par with those for all non-communicable diseases, including cancer, obesity, diabetes, heart and respiratory diseases (Sethi et al., 2013). Those who are not resilient to violence exposure in childhood may be more likely to perpetrate violence themselves (Gil-González et al., 2008). Individuals with a history of abuse or neglect have been shown to have more involvement with child welfare services and the juvenile justice system; they are also at higher risk for sexual assault and intimate partner violence as adults (Hetzel & McCanne, 2005). Survivors of child abuse also experience higher rates of homelessness (Stein, Leslie, & Nyamathi, 2002). The monetary cost of abuse and neglect to the US as a nation is estimated to be between \$80 and \$100 billion per year (Wang & Holton, 2007; Gelles & Perlman, 2012). Such research points to the need for preventive investment in strengthening families.

It is important to state that not all individuals who experience trauma are destined to have long-lasting effects, as a conversation focused on trauma alone neglects strength and resilience. However, those who do not have the internal or external tools to cope with trauma may go on to develop chronic mental health problems such as [posttraumatic stress disorder \(PTSD\)](#), depression, or anxiety. **PTSD is also frequently comorbid with depression and/or anxiety. Individuals who experience early and repeated trauma, particularly trauma in their early relationships, may develop “complex” PTSD, in that they may experience additional symptoms alongside other PTSD symptoms, such as core changes to their self-concept and impairments in the way they adapt to stressful life events across the lifespan (Cloitre et al., 2009; Herman, 1992).**



Trauma exposure and the response to it (in the form of PTSD and other comorbidities) contribute to what has been described as a “cycle” of violence and psychiatric vulnerability (Sperlich et al., 2017). Both “nature” and “nurture” have been suggested historically as affecting cycles of intergenerational vulnerability (Black, Sussman, & Unger, 2010; ChildWelfare Information Gateway, 2008; Schuetze & Eiden, 2005), whereas other contemporary explanations suggest a role for both, in that heredity and epigenetic adaptations, in combination with a compromised caregiving environment, are simultaneously contributing to vulnerability in families (e.g., Meaney, 2010; Uddin et al., 2010).

Trauma Affects Pregnancy. Although it is possible that any number of different types of trauma exposures might affect a woman’s experience of pregnancy, there is compelling evidence to suggest that childhood maltreatment and intimate partner violence present particular challenges (Howard, Oram, Galley, Trevillion, & Feder, 2013; Leeners, Stiller, Block, Görres, & Rath, 2010; Möhler et al., 2008; Seng, Kane Low, Sperlich, Ronis, & Liberzon, 2011; Seng et al., 2013; Seng & Taylor, 2017; Sperlich et al., 2017).

Twenty percent or more of pregnant women in the US are survivors of childhood maltreatment, and are at increased risk for PTSD and depression that extends into their pregnancies (Gold & Marcus, 2008; Seng et al., 2009; Seng et al., 2011). A large community study found that 8% of women overall meet full diagnostic criteria for PTSD during their pregnancy, a number that is stratified by sociodemographic disadvantage—(2.7% for those with low levels of disadvantage, versus 13.9% of those with high levels) (Seng et al., 2009). The study also found that the highest risk for having PTSD in pregnancy is for those who have a history of abuse, and found high comorbidity between PTSD and depression (Seng et al., 2009).



A challenge for women survivors of maltreatment is the potential for “triggers” (reminders of trauma), with some women reporting that posttraumatic stress symptoms, including re-experiencing, avoidance and numbing, and arousal are problematic features of their pregnancy and birth experiences (Seng et al., 2009;

Sperlich & Seng, 2008). Maternity care procedures such as having internal pelvic examinations, feeling out of control of one’s own body, and being in pain can be triggering of past abuse and especially challenging (Hobbins 2003; Simkin & Klaus, 2004; Sperlich & Seng, 2008).

In addition to risk for developing PTSD and/or depression based on childhood maltreatment, women may have been exposed to further violence proximally to

their pregnancy. Women are more at risk for being re-victimized in adulthood if they have a history of childhood maltreatment (Barnes, Knoll, Putnam, & Trickett, 2009; Messman-Moore & Long, 2003). Some women are victimized during their pregnancies, which can cause a range of difficulties including medical injury trauma but also PTSD symptoms, depression, suicide attempts, substance use, and a variety of pregnancy and birth complications (Kiely, El-Mohandes, El-Khorazaty, & Gantz, 2010). In fact, intimate partner violence is the most frequently experienced traumatic exposure for pregnant women (Mendez-Figueroa, Dahlke, Vrees, & Rouse, 2013).

Although the mechanisms are not yet fully understood, childhood maltreatment survivors with PTSD have increased risk for having a low birth weight baby or a premature baby, above and beyond the effects of other stressors in their lives (Morland et al., 2007; Rogal et al., 2007; Seng et al., 2011; Shaw et al., 2014; Yonkers et al., 2014). Other stressors include the effects of substance use while pregnant, which may also directly bear influence on prematurity and low birth weight of babies (e.g., Soto & Bahado-Singh, 2013). Women with PTSD and/or depression are more at risk for substance use during pregnancy (Horrigan, Schroeder, & Schaffer, 2000; Morland et al., 2007; Seng et al., 2009), perhaps using substances to cope with the noxious effects of PTSD due to a history of maltreatment, or current interpersonal violence (Cohen, Field, Campbell, & Hien, 2013; Einav, Sela, & Weiniger, 2013).

Women who are of refugee background may be particularly at risk during pregnancy, due to the preponderance of stressors experienced prior to and post-settlement (Austin & Highet, 2011; Collins, Zimmerman, & Howard, 2011). They may also be less likely than women not of refugee background to seek help for mental health challenges (Donnelly et al., 2011). Overall, it is clear that trauma is exerting quite an influence on the experience of women during their pregnancies.

Trauma Affects the Postpartum Period. A history of trauma exposure also exerts influence in the postpartum period, associated with both postpartum depression and postpartum PTSD (Leeners, Richter-Appelt, Imthurn, & Rath, 2006; Seng et al., 2013). Added to this is the compounding effects of any additional

trauma that may have occurred during the pregnancy, including medical complications, or having experienced the birth as traumatic—which can also lead to posttraumatic stress (Alcorn, O'Donovan, Patrick, Creedy, & Devilly, 2010; Ayers, Eagle, & Waring, 2006).

Posttraumatic stress appears to remit somewhat immediately following delivery, but remains elevated in at-risk samples (15.7%, compared to 3.1% for community samples; Grekin & O'Hara, 2014), and is significantly





comorbid with depression in the postpartum period (Grekin & O'Hara, 2014; Seng et al., 2013). Estimates of the prevalence of depression during the first six months after delivery range from 13% to 19% (O'Hara & McCabe, 2013), and as many as 14.5% of women may have a new onset of major or minor depression during the first three months postpartum (Gaynes et al., 2005).

Early parenting is shown to be adversely affected by postpartum depression. Postpartum depression is implicated in impairments in early mother/infant bonding (Moehler, Brunner, Wiebel, Reck, & Resch, 2006; Seng et al., 2013), and insecure or compromised mother/infant attachments and interactions (Beck, 1995; Field, 2010; Hipwell, Goosens, Melhuish, & Kumar, 2000; Kuscu et al., 2008; Martins & Gaffin, 2000; McMahon, Barnett, Kowalenko, & Tennant 2006; Shin, Park, & Kim, 2006; Murray & Cooper, 1997). Parental caregiving activities of mothers with depression also appear to be compromised, affecting feeding practices (particularly breastfeeding), sleep routines, well-child visits, vaccinations, and safety practices (Field, 2010; Zajicek-Farber, 2009).

A very serious risk for mothers, babies, and their families alike is maternal suicide, which is responsible for about 20% of postpartum maternal deaths worldwide (Lindahl et al., 2005). In a large US study, 19.5% of women who screened positive for postpartum depression endorsed suicide ideation (Wisner et al., 2013). For women so afflicted, caring for an infant likely proves more challenging.

Caring for an infant can be a real challenge for any parent with or without such afflictions; this is particularly true for those whose infant may be experiencing incessant crying and may be difficult to comfort, or who has feeding and/or sleep problems. Women with unresolved trauma, especially those with PTSD, may be triggered by such behaviors and less able to cope in ways that regulate rather than disorganize the infant (Swain et al., 2012). Caring for a high-risk or premature baby can also contribute to both depression and PTSD for parents (Davis, Edwards, Mohay, & Wollin, 2003; Grigoriadis et al., 2013; Holditch-Davis, Bartlett, Blickman, & Miles, 2003; Kersting et al., 2004).

Trauma Affects Young Children. Young children continue to be at risk from trauma beyond infancy, either indirectly from their experience of being cared for by a parent who has a history of traumatic exposure and/or mental health challenges, or directly at risk for abuse and neglect. The effects of maternal postpartum depression for young children include more behavioral problems to age 9 (Luoma et al., 2001), lower IQ scores, more attentional problems, and difficulties in math reasoning at age 11 (Hay et al., 2001). Both maternal depression and anxiety are implicated in math underachieving in adolescents (Pearson et al., 2016). Maternal history of trauma is associated with anxieties about intimacy in parenting (Douglas, 2000), and poorer behaviors in children ages 4–7 (Collishaw et al., 2007). Postpartum PTSD



in parents has also been associated with parent-child dysfunctional interaction and child behavioral problems (Salloum, Stover, Swaidan, & Storch, 2014). Depression in mothers has been shown to be highly correlated with depression in children, through age 15 (Hammen & Brennan, 2003) and age 18 (Pearson et al., 2013).



Direct effects of a parent's history of trauma or mental health challenges have also been described in the literature and are likely predicated on unresolved and untreated trauma and mental health sequelae.

Many women are resilient to the trauma and stress they have experienced, and benefit from protective factors such as their perception of their own parental care, the peer relationships they had as adolescents,

the quality of their adult intimate relationships, and beneficial innate personality characteristics (Collishaw, 1997). However, some mothers are not resilient to the effects of trauma and this can have real implications for their parenting. Researchers have found associations between a mother's status as a childhood abuse survivor and increases in intrusive (Moehler, Biringen, & Poustka, 2007) and punitive parenting styles (DiLillo & Damashek, 2003; Schuetze & Eiden, 2005; van Ee, Kleber & Mooren, 2012).

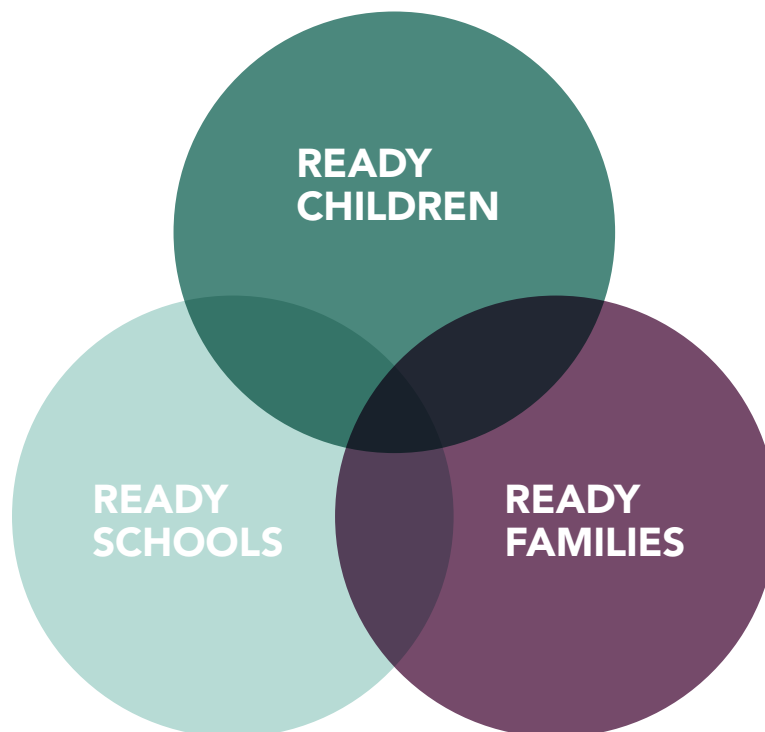
Beyond punitive disciplinary styles, there is risk for direct parent-child abuse. While it is certainly not true that a mother who was herself abused will abuse her own child, still her child is at increased risk for maltreatment, whether by the mother herself (Spieker, Bensley, McMahon, Fung, & Ossiander, 1996; Sroufe, Egeland, Carlson, & Collins, 2005), or by an intimate partner or member of the mother's family-of-origin (McCloskey & Bailey, 2000). A comparison of abused children and non-abused children shows that PTSD and depression were frequent diagnoses among mothers of abused children (Famularo, Kinscherff, & Fenton, 1992). This association may be mediated by substance use problems (Appleyard, Berlin, Rosanbalm, & Dodge, 2011).

This review of effects of trauma during pregnancy, postpartum, and early childhood demonstrates that intergenerational cycles of abuse and psychiatric vulnerabilities intersect during the childbearing year and influence early development period of children and are further exacerbated by circumstances of poverty. It is clear that these cycles can affect mental and physical health, and well-being, presenting challenges to young children that may adversely affect their readiness for school. Taken together, both the indirect and direct effects of trauma have implications across many domains, including how children will be able to grow, behave, learn, and achieve.



School Readiness

Addressing social and emotional development is part of what a child needs to be prepared for school. As discussed above, both circumstances of chronic scarcity and trauma can degrade a child's overall health and wellbeing, and can impede development, particularly in the early years. Research has indicated that children from socioeconomically under-resourced backgrounds may be years behind economically advantaged children at the point of entry into kindergarten (Brooks-Gunn, Britto and Brady 1999). School readiness has been recognized as an important marker of future success. Although defining school readiness continues to be debated, in a report for the [United Nations Children's Fund \(UNICEF, 2012\)](#), author Britto provides a conceptual framework for defining and delineating school readiness, which includes three dimensions. The first dimension is "ready children," which focuses on children's learning and development. The second dimension is "ready schools," which focuses on the school environment along with practices that foster and support smooth transition into schools, and the third dimension is "ready families," focusing on caregiver attitudes and involvement. Britto (2012) stresses that all three dimensions are important and must work in tandem. Following an increasing focus in the 1990s, school readiness was mandated as the primary goal in the 1998 Head Start legislation, and has been a primary goal since (Snow, 2006). Many studies have underscored the effectiveness of early education for school readiness, particularly for children with socioeconomic disadvantage (e.g., Welsh, Nix, Blair, Bierman, & Nelson, 2010).





Important to note here is the established connection between poverty and school readiness. As we have described in great detail above, experiences of trauma can obstruct a child's readiness for school; poverty has much the same deleterious effects, making it an arduous task to disentangle effects of poverty and effects of trauma when looking at the outcomes of school readiness or school related behaviors. Researchers with the Brookings Institute (Isaacs & Mangunson, 2011) teased apart income and maternal education as predictors of a child's school readiness. Overall school readiness among children living in households earning less than \$25,000 annually was 51% compared to 85% among children living in households earning over \$100,000, with similar patterns noted with regard to maternal education; 47% of children in the sample born to a mother with less than a high school education were deemed to be school ready compared to 85% of children in the sample born to a mother with a Master's degree or more. Similarly, Isaacs & Mangunson (2011) found that an increase in maternal education led to a modest improvement in a child's math and reading scores.

Historically, school readiness has been examined with a narrow focus on parenting behaviors. As discussed in an article by Brooks-Gunn and Markman (2005), research indicates that there are "racial" and ethnic differences in parenting, such that Black and Hispanic mothers have been found to speak and read less often with their children than their White counterparts. Although it is common knowledge that one's parenting style and skills have a profound influence on a child's wellbeing, it is important to contextualize parenting styles and behaviors. Responsive and structured parenting have been shown to positively relate to school readiness (Connell & Prinz, 2002), however poverty and adversity have BOTH been implicated in undermining responsive and structured parenting (Cohen, Hien, & Batchelder, 2008; Isaacs & Mangunson, 2011; Williamson et al., 2017). Thus, addressing both poverty and trauma together is imperative.





When thinking of Winnicott's (1947) famous quote—"there is no such thing as a baby..."—if a child is living in circumstances of poverty, so too is the child's caregiver. Once again it is important to consider the influence of chronic scarcity and of adverse experiences on parenting. Slack, Holl, McDaniel, Yoo, & Bolger

(2004) explored the mechanisms of the association between poverty and child neglect. Their findings indicate that perceived material hardship and infrequent employment are predictors of child neglect. This highlights the concept of Ideas42 authors Daminger, Hayes, Barrows, & Wright

(2015), illustrating debilitating consequences of poverty on one's capacity to cope, or in this instance, parent in a responsive and nurturing fashion.

"There is no such thing as a baby...if you set out to describe a baby, you will find you are describing a baby and someone."

Donald Winnicott, 1947, English Pediatrician

In this review of literature we have established that income, or lack there-of, and maternal education influence school readiness. Circumstances of poverty are largely detrimental to one's health and wellbeing, leaving individuals at greater risk of psychosocial, emotional, physical, environmental, and economic vulnerability. Children living in circumstances of poverty, particularly Black children (those experiencing disproportionately high rates of poverty), experience significantly higher rates of maltreatment. Adverse childhood events and/or traumatic events have lasting consequences that reverberate through a family's sense of safety, wellbeing, and capacity to cope, and that circumstances of poverty and trauma are often intergenerational experiences that influence health and development across the lifespan, impinging on the life trajectories.



The Need for Trauma-Informed Care for Mothers, Babies and Young Children

There are many important policies, services, and programs already in place directed at supporting mothers, babies, and young children. For example, programs like the USDA's [Women, Infant, and Children \(WIC\)](#), provides essential support across the US for low income women and their children through the provision of supplemental foods, health care referrals, and nutrition education for pregnant women, infants and children up to age five, which supports many families affected by trauma, but is not addressing trauma directly.

Professional organizations of clinicians who work with pregnant women have recognized the impact of trauma on the lives of the women they care for and are on record for recommending screening for trauma and abuse. For instance, the [American College of Obstetricians and Gynecologists \(ACOG\)](#) has recommended that all women be screened for psychosocial stressors including barriers to care, unstable housing, unintended pregnancy, communication barriers, nutrition, tobacco use, substance use, depression, safety, intimate partner violence, and stress (ACOG, 2006). Yet, our current system of prenatal care is not doing enough to identify and treat women with traumatic sequelae and mental health challenges, particularly for women with sociodemographic disadvantages (Walker Sterling, Guy, & Mahometa, 2013). Although there have been improvements overall in the rate of engaging women in early prenatal care, this has not necessarily translated into concurrent change in adverse pregnancy outcomes (Misra, Guyer, & Allison, 2003),



nor has routine and early screening for depression among typical perinatal providers translated into effective treatment engagement (Gavin et al., 2015). Overall, there appears to be discontinuity in service provision in antenatal health care settings (Austin, 2003). This is despite the rise of the Integrated Behavioral Health Model of Care (IBHMC; Blount, 2003), which addresses physical health and mental health in tandem, and is an ideal called for by organizations

such as the Lancet Global Mental Health Group (Group, L. G. M. H., 2007), and the Substance Abuse and Mental Health Services Administration (SAMHSA).

For true integration of care, more must be done to address the effects of trauma and engage women and families. [SAMHSA's National Center for Trauma-Informed Care \(NCTIC\)](#) organizes information about how to begin this process. SAMHSA defines trauma-informed care as “(...) an approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their lives”. Becoming trauma-informed means



adoption of the four “R’s”—an approach that “realizes the widespread impact of trauma (...), recognizes the signs and symptoms of trauma (...), *responds* by fully integrating knowledge about trauma into policies, procedures, and practices (...) and seeks to actively resist *re-traumatization*” (<https://www.samhsa.gov/nctic/trauma-interventions>). This is consistent with the overall Hippocratic injunction, “do no harm” although in the case of trauma, it might be better worded as “do no *further* harm.”



Becoming trauma-informed is not a treatment in and of itself, but rather a set of guiding principles that can be used across multiple settings (programs, agencies, organizations). Initially proposed by Harris and Fallot (2001), SAMHSA’s six key principles include attention to 1) safety, 2) trustworthiness and transparency, 3) peer support, 4) collaboration and mutuality, 5) empowerment, voice and choice, and 6) cultural, historical, and gender issues. Becoming trauma-informed implies systems change, and calls for the development and adoption of trauma-specific interventions and treatments to promote

healing in a more focused way for affected individuals. To clarify, to be trauma-informed is to apply a lens in which there is a universal recognition of trauma, and the consequences and manifestations thereof, in the lives of all around us, which then dictates the ways in which we engage and support individuals in every facet of an agency or program. Trauma-informed care in and of itself does not function as a treatment of trauma; it is a value system that guides the culture, policies, and processes of an organization. Trauma specific interventions, although often born out of a trauma-informed perspective, are employed to specifically address the symptoms of trauma and promote recovery.

SAMHSA has identified several trauma-specific and well-known interventions that have been used extensively in public health settings on the NCTIC website such as Eye Movement Desensitization and Reprocessing (EMDR; Shapiro & Forrest, 2016). In health system settings, such trauma-specific treatments (and the necessary resources to implement them) will often flow from a formal mental health diagnosis, and require integration of health and behavioral health services to sustain them. Although several of these are directed at treating trauma, PTSD, and gender-based violence (e.g., TREM; Toussaint, Bornemann, & Graeber, 2007), none of the trauma-specific treatments identified on SAMHSA’s NCTIC website are specifically directed at traumatic concerns during childbearing and early parenting.

The experience of pregnancy and early parenting typically involves multiple clinical appointments and exchanges with health care professionals, which present real opportunities for engaging women and their families to services that might help them heal from the effects of trauma. However, to promote effectiveness, these services need to be positioned in trauma-informed environments and trauma-

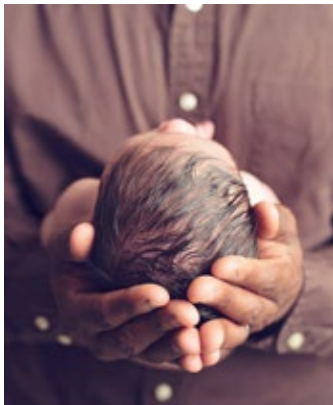


specific in nature. Fortunately, there are promising programs, interventions, and services that are taking trauma into account, and which deserve attention, adoption, and expansion specifically for pregnant women, infants and young children.

Trauma-Specific Prevention, Intervention, & Treatment

Although not always readily available depending on locale, there are emerging interventions and treatments for addressing trauma. Trauma-specific programs and interventions can be broadly categorized as those aimed at universal prevention, those targeted interventions and treatments, and those that have been adapted for the context of addressing trauma.

Universal Prevention. Prevention programs may not explicitly address trauma in their aims, but have promise because they provide opportunity to address the effects of trauma through assistance with mental health and/or parent-child interaction. Examples of universal prevention programs are continuity of care models like health visiting. In areas where health visiting programs are available, nurses and/or social workers provide at-home support for families, typically based either on sociodemographic disadvantage or mental health and child welfare concerns. Perinatal home visiting programs such as the Nurse Family Partnership can provide continuity of care through extension of the clinician-client relationship from early pregnancy into the child's toddlerhood. The Nurse Family Partnership has been studied extensively, and has a solid evidence base for improving maternal health and child development outcomes (e.g., Olds, 2006; Olds et al., 2010).



Whether delivered at home or in clinic, the practice of infant mental health therapy has the goal of improving parent-child interaction and attachment, and promoting positive parenting. A foundational understanding within the field of infant mental health is the notion that the experience of one's own childhood upbringing and the parenting received, when maladaptive, represent ["ghosts in the nursery"](#) that have direct bearing on how one interacts with their baby and child in the present day (Fraiberg, Adelson, & Shapiro, 1980). As such, infant

mental health practitioners can help a mother to address past trauma by discovering the ways in which her history has bearing on her parenting and developing healthy strategies for current interactions. It should be noted that Fraiberg and her colleagues' work has provided a foundation for many models of infant mental health home-visiting programs. Some of these have been tested empirically, including infant-parent psychotherapy (Lieberman, Silverman, & Pawl, 1999) the UCLA Family Development project (Heinicke et al., 1999), and the Circle of Security (Marvin, Cooper, Hoffman & Powell, 2002), and have demonstrated effectiveness at improving the quality of parent/infant interaction and attachment.



Parenting education is another example of universal prevention. Many parent education programs are funded in the US by the [Federal Children's Bureau's Community Based Child Abuse and Neglect Prevention \(CBCAP\)](#) grants, as authorized by the Child Abuse Prevention and Treatment Act (CAPTA). CAPTA identifies parent education as a core prevention service, and CBCAP grants fund parent education programs either as stand-alone efforts or as part of broader strategies. Many of the resources to support these grant initiatives are freely available through the [US Department of Health & Human Service's Child Welfare Information Gateway](#), and include parenting education materials specific to trauma concerns for children, such as a [fact sheet on parenting a child who has experienced abuse or neglect](#). Clinicians in a variety of settings can make such materials available to their clients, which is helpful not only for provision of basic information, but also as a potential tool for interesting parents in more extensive treatment engagement.



Provider education is another important universal and critical approach. Metasynthesis of qualitative research on pregnant trauma survivors' experience of interfacing with medical providers shows that undergoing medical procedures that impinge on body integrity like vaginal examinations, delivery procedures, breastfeeding support, etc., are triggers that can produce PTSD reactions (Montgomery, Pope, & Rogers, 2015). It is critical that health care providers learn to become more informed about the ways in which care can be triggering, and

how to respond therapeutically to situations where the women under their care are being triggered and having adverse reactions. Concerned clinicians are beginning to provide guidance for trauma-informed caregiving (e.g., recommendations for obstetricians asking patients about abuse; White, Danis, & Gillece, 2016). Yet education in this realm will need to go beyond published recommendations and even co-locating services, which is the principal way integration of health and behavioral health is happening in the US, in order for the trauma-informed perspective to take hold. It will require true integration; with mental health providers learning more about medical procedures that are potential triggering events, and health providers like obstetricians, midwives, and nurses learning more about how they might be better able to respond therapeutically to a reactive client, and learn strategies for “doing no further harm” in the first place.

Early childhood education is another important example of universal prevention. Programs and interventions that seek to improve parent-child attachment and the quality of interaction are important not only for general mental health but also for a child's social and emotional development, which may be adversely affected



by trauma when we consider that young children (0 to 5) are more likely than persons in any other age group to experience maltreatment and neglect (DeVooght, McCoy-Roth, & Freundlich 2011). Because early trauma occurs during critical epochs of brain development and organization, it may have profound effects—and young children will require the benefits of reparative relationships to counteract these effects (Ludy-Dobson, Perry, & Gil, 2010). Ideally, early education can contribute key support for this repair process, including respite and support, bolstering of a child's



emotional resources, and trauma responsiveness (Brinamen & Page, 2012). As such, many have called for expansion of preschool education to directly address social and emotional competence (e.g., Blair 2002). Therefore, it is not hard to argue that Head Start, Early Head Start, and other preschool programs are important universal interventions for promoting school readiness and increasing capacity for cognitive, social, and emotional development that may be hampered by the effects of traumatic exposure.

Targeted Interventions & Treatments. There is a difference between a trauma-specific intervention and a trauma-specific treatment. An intervention could be useful for individuals who self-identify as trauma survivors and may benefit them even if they are fairly resilient to the effects of trauma (for instance, psychoeducation), whereas treatments are those services provided based on individual assessment of trauma history and current manifestations of traumatic reactions and effects (for instance, a trauma-focused individual psychotherapy). It is important to state that although evidence for feasibility and effectiveness have been reported for many of the interventions and treatments reviewed, that does not mean that the interventions and treatments are readily available. The ability to scale up interventions and treatments so that they are widely available for clinical use (as opposed to exclusive research use) is dependent on organizational-, governmental-, and agency-level commitments, including procurement of the policies, funding, and personnel necessary for development and implementation.

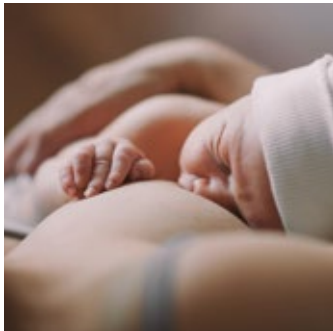
Interventions. There are a few interventions that aim to broadly help women affected by trauma during the childbearing year. These include home-visiting, a group intervention, and psychoeducation with tutor support.

A program that combines the preventative aims of nurse home-visiting programs and principles of parent-infant psychotherapy is *Minding the Baby* (Sadler et al., 2013). Directed at vulnerable mothers and babies to age two, *Minding the Baby* was developed to promote 'reflective functioning,' a concept which describes a mother's capacity to envision mental states (thoughts, feelings, needs, desires) in her baby, with the goal of preventing and/or repairing mother/baby relationship disruptions



stemming from the mother's early trauma and derailed attachment history. The program employs both nurses and social workers in delivery of the intervention, and has been successful in increasing reflective functioning in mothers and promoting secure attachments.

Another program that is directed at building secure attachment bonds between young mothers (age 15–21) and their young children (0–6) is Mom Power (LePlatte et al., 2012; Muzik et al., 2015). Delivered in a ten-week group format, Mom Power focuses on strengthening mother-child interactions, improving parenting skills, teaching self-care practices in order to cope with stressful life experiences and



mental health symptoms, and increasing social and healthcare support. Research on the intervention has shown that Mom Power contributes to reductions in depression, PTSD, and caregiving helplessness, and has been well-received by the study participants.



A program that has been developed to specifically address the pregnancy-specific needs of traumatic stress-affected abuse survivors is the Survivor Moms' Companion (Sperlich et al., 2011; Seng et al., 2011). The intervention is a ten-module self-study program with tutoring support from a health or mental health care provider. It was developed in response to the needs of pregnant survivors of abuse identified in prior qualitative research (Sperlich & Seng, 2008), and includes simulated problem solving and skills practice. Research on the intervention has shown improvements in anger expression, interpersonal reactivity, and PTSD symptom reduction and management, despite the presence of triggers (Seng et al., 2011). Participants have also experienced improvements in birth experience, postnatal mental health status, and maternal to infant bonding (Rowe et al., 2014). Overall, Survivor Mom's Companion is showing promising results and can be added to the growing number of interventions available to women.



Treatments. Treatments specific to addressing mental health challenges related to trauma history have also been developed.

An influential individual therapy treatment that was originally developed for children who have been sexually abused and their non-offending parents or caretakers is *Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)* (Cohen, Mannarino, & Deblinger, 2006). Research on TF-CBT has shown that it has been successful in reducing a variety of symptoms and problems in children and their caregivers,



including for children who have experienced domestic violence, traumatic loss, and multiple traumas (Cohen, Deblinger, Mannarino, & Steer, 2004; Cohen, Mannarino, & Deblinger, 2010), and has been found to be highly effective (Silverman et al., 2008). It has been used for treatment with children as young as three and four years old (Deblinger, Mannarino, Cohen, Runyon, & Steer, 2011; Scheeringa, Weems, Cohen, Amaya-Jackson, & Guthrie, 2011).

In order to address personality disorders that are rooted in trauma, therapies with a basis in mindfulness and compassion have been developed. One such therapy is *Compassion Focused Cognitive Therapy (CFT)* (Lee, 2009). CFT addresses the effect of constant threat and hyperarousal that is a feature of the lives of trauma survivors, and places an emphasis on ameliorating the shame and self-criticism that are frequent results of traumatic exposure. It targets the activation of the self-soothing system for regulating threat-based emotions including anger, fear, disgust, and shame. Research has shown benefits for CFT when used with a home-visiting program in the United Kingdom (Renshaw & Wrigley, 2015); however, it has not yet been researched for independent effectiveness with pregnant or postpartum women.

The aim of *Parent-Infant Psychotherapy (PIP)* is to help mothers address their own past trauma and to foster healthy mother-baby relationships (Baradon et al., 2010). These types of psycho-dynamically oriented therapy focus on how internal representation of experiences influence interpersonal relationships, and uses the relationship between the therapist and client as a tool for growth and fostering awareness of such dynamics. A review of the effectiveness of such therapies (Barlow et al., 2015) indicated that PIP is a promising model for improving infant attachment in vulnerable families. However, there was no difference between PIP and other forms of therapies such as counseling or cognitive behavior therapy; suggesting that more research is needed to look at mediating factors such as mental health, reflective functioning, and parent-infant interaction.

Parent-child Interaction Therapy (PCIT) has been used for treating abused and at risk children ages 2 to 8, and involves both the children and their caregivers (Eyberg, Boggs, & Algina, 1995). The model for PCIT involves active coaching in the part of a therapist while caregivers interact with their child, and includes teaching strategies for promoting positive behaviors in children and adopting prosocial ways of interacting. Research, including over 30 randomized clinical outcome studies, shows that PCIT is effective at treating vulnerable families and children with behavior problems (Taylor & Ingelman, 2007).





Another approach used for facilitating improvements in parent-infant interaction is video feedback (Rusconi-Serpa, Rossignol, & McDonough, 2009). Video-taping parent-infant and parent-child interactions has proven to be a useful tool for conjunctive use with several different therapies and situations, such as for reducing the impact of preterm birth (Hoffenkamp et al., 2015) and its use has contributed to increases in maternal sensitivity, and improvements in mother-infant attachment.

We have already discussed the importance of early education as a universal preventative approach to addressing the effects of trauma; however, there is also



a model of early education that more specifically addresses trauma and as such constitutes a treatment. Head Start Trauma Start is an early education and mental health cross-systems partnership designed to work within Head Start classroom settings with a goal of decreasing the stress of chronic trauma, fostering socio-emotional development, and creating a trauma-informed school culture (Holmes, Levy, Smith, Pinne, & Neese, 2014). The program emphasizes tools and skills that can provide daily strategies for coping with stress related to traumatic exposures such as loss, violence, and abuse.

Preliminary evaluation data is positive and suggests a path forward to bring a trauma-informed perspective and resource to early education communities.

Adaptations. There are some interventions that have been originally developed for other purposes that would likely have valence for treating those with a maltreatment history and/or posttraumatic stress. For instance, a mindfulness yoga intervention for pregnant women which reported findings related to depression and attachment (Muzik, Hamilton, Rosenblum, Waxler, & Hadi, 2012) would most likely prove useful for treating trauma and PTSD since both mindfulness and yoga have some evidence with other individuals in non-pregnant populations (Van der Kolk et al., 2014; King et al., 2013; Spinazzola et al., 2011). In fact, a preliminary study has been published which shows initial positive feasibility and acceptability for such an approach (Beddoe, Paul Yang, Kennedy, Weiss, & Lee, 2009).

Instruction in mindfulness techniques more broadly has also been adapted for use as a pregnancy intervention (Dunn, Hanieh, Roberts, & Powrie, 2012). Participants to Dunn and colleagues' eight-week pilot study of a mindfulness-based cognitive therapy group for pregnant women reported declines in measurements of depression, stress, and anxiety, which were maintained to the postpartum period.

Another example of an adaptation is the use of music therapy in pregnancy for addressing psychological health. A randomized study has been implemented that provided women with a music intervention (prescribed daily listening) with



the aim of reducing stress (Chang, Chen, & Huang, 2008). The researchers found significant improvements in perception of stress, and reduction in anxiety and depressive symptoms.



Narrative Exposure Therapy is a treatment modality that has been used for many traumatized populations (Schauer, Neuner, & Elbert, 2011). It is a process that is used to facilitate therapeutic processing of traumatic memories. NET has also adapted for use with pregnant low-income adolescents to study the effectiveness for reducing PTSD and depression (Volpe, Quinn, Resch, Douglas, & Cerulli, 2016). Volpe and colleagues found favorable attitudes about the use of NET for pregnant adolescents, and identified what barriers exist for uptake of the intervention for future use.

It is likely that many more treatments currently exist for treating trauma and its effects more broadly could be effectively adapted for use in pregnancy, postpartum, and parenting.



The Need for Addressing Trauma in Western New York

As is discussed previously, circumstances of poverty increase a child's vulnerability to violence, neglect, abuse, and the like. With rates as high as 33% of children under the age of 5 living in poverty across all 8 counties of WNY, unemployment rates among adults ranging from 6.7 to 9.2 %, with up to 4.4% of adults across WNY achieving less than a 9th grade education ([US Census Bureau, 2016](#)), the need for services, programs, and supports is made readily apparent. According to the most recent [Community Health Assessment of Erie County](#) (2017), "13.7% of families in Erie County have a single, female head of household and greater than 30% of these families live below the poverty level"(Erie County Department of Health, 2016). Such statistics may be on the rise, in part by the growing number of New Americans (refugees) being resettled in WNY.



Consequences of hardship manifest in resilient yet challenged communities in terms of health. Such hardships, and consequences thereof, disproportionately affect those particularly vulnerable among us. For example, the rate of low-birth weight (less than 2500g) and very low birth weight (less than 1500g) and preterm (less than 37 of 40 weeks gestation) infants are far more pronounced among women and infants who identify or are identified as African American in WNY; nearly double the number of very low birth weight and very preterm infants than that of their white counterparts ([National Center for Health Statistics, 2010](#)). Similar patterns are seen in a host of health conditions such as asthma, hypertension, and diabetes—all known risks to the health of mom and baby.

WNY is also not immune to the opioid epidemic ravaging the nation, with over 50 opioid related deaths in the first two months of 2017 in Erie County alone (Tan, 2017). Trauma experiences and substance use disorders are strongly correlated; with past trauma often fueling substance use (Swendsen et al., 2010).





Although no concrete numbers exist as to how many mothers and children among us in WNY are survivors of childhood trauma or traumatic events or circumstances presently, we can extrapolate from county statistics which indicate significant vulnerability; 43.6% of children in Erie County are receiving a free or reduced lunch at school and 54.1% in Orleans County; a nearly 7% increase in the number of



child abuse/maltreatment cases reported in Erie County, an 11.3 % increase in Cattaraugus County since 2009 (Council on Children and Families, Kids' Wellbeing Indicators Clearing House (KWIC), 2016). We can also employ a trauma-informed lens to the eight counties of WNY and function from a place that assumes there are a vast number of survivors walking with us each day. We can assume that the thousands of children presently in the foster care system in WNY are facing challenges related to trauma. We can assume that there are mothers across all 8 counties who are engaging in health and mental health

services who have histories of trauma or are working through traumatic experiences presently, and that their struggles are infusing their interactions with their children. We can safely assume that trauma is only one piece of a complicated puzzle that is the psychosocial, economic, physical, and emotional climate, both in and out of the home that comes to bear on a child's readiness for school.



Scan of Services and Programs in WNY Engaging Women and Children Who Have Experienced Trauma

Methodology. Recognizing the relevance and pervasiveness of trauma among mothers and children across WNY and the impact of trauma on child development, health, well-being, and school readiness, the Health Foundation of Western and Central New York (HFWCNY) tasked a team of two maternal and child health focused professors, Dr. Whitney E Mendel of Daemen College, and Dr. Mickey Sperlich of the University at Buffalo's School of Social Work, along with graduate students Michelle Larimore (Daemen) and Katie Blakely (UB), to suss out what is available to mothers and young children across WNY by conducting a comprehensive inventory of trauma related services, supports, and programs within the 8 counties.



Prior to contacting any organizations, the team compiled a list of organizations/agencies in each of the eight counties through searching a public resource, WNY 211, and through broad internet searches using such terms as 'trauma', 'mental health', and 'maternal and child'. Agencies that provide broader services to women and children were also included in the list, as they were regarded as referral sources. Such agencies included the United Way of Buffalo and Erie County, Buffalo Prenatal Perinatal Network, and the Family Justice Center. The [Institute on Trauma and Trauma Informed Care](#) of the University at Buffalo and members of their Trauma Coalition were consulted as

well as local officials and other county wide stakeholders, such as the Commissioner of the Erie County Department of Social Services and members of the Chautauqua Tapestry in an effort to capture a more representative and comprehensive list.

Following the initial compilation of organizations/agencies, members of the team reached out by phone or by email to establish points of contact within each agency/program. Points of contact were also established by informal consultation with active members in the trauma-focused community. Multiple attempts were made to reach established points of contact, including multiple phone calls and/or emails (when available). Once contact was made, a brief phone or in-person interview was conducted by one of the team members. A series of questions was asked of each agency contact. In some instances, attempts to reach points of contact were not successful, at which point members of the team reviewed agency websites in an effort to garner the information listed below. The findings to be discussed include a total of 68 agency/program responses (interview, email correspondence, or website review), out of approximately 201 agencies/programs contacted. Data collection took place between January and May of 2017.



Table 1. Number of type of organizations who participated in the scan by county

TYPE OF ORGANIZATION >>	Health & Human Service	County	Charitable	Education	Mental Health / Substance Use	Crisis
Erie	23	2	2	2	9	4
Wyoming	7	4	1		3	1
Allegany	5	1			1	
Genesee	8	2	1	3	6	3
Orleans	9	6		4	1	1
Chautauqua	2	6	2		4	4
Cattaraugus	5	2	1		3	1
Niagara	10	5	5	1	5	3

Questions asked of agencies addressed the following topics:

- › Basic demographics of the overall population served and that of women and children
- › Definition of trauma held by the organization (If applicable)
- › Services, programs, interventions, and supports available to women and children that are trauma related
- › Funding sources for such offerings
- › Partnerships or collaborations in providing trauma-related services
- › Programs/services under construction
- › Current challenges in the provision of trauma-related programs/services
- › Perceived needs among the women and children they are serving.



Responses to each question were noted by the interviewing team member and entered into a Google survey form, which both housed individual agency responses and aggregated all the data collected. The two lead consultants reviewed the



aggregate data by question, independent of one another to determine the key concepts that emerged from the data. The independent key concepts were then compared and consensus was established between the two consultants. The agreed upon concepts were then provided to the graduate assistants for further review.

The following is a synthesis of the findings from the scan, highlights of promising programs and/or services, identified gaps in existing programs and/or services, and recommendations for funding directions. It is important to note that the following

report is informed by the extant empirical literature and other relevant work related to poverty, school readiness, and trauma, as well as the cross-section of data we were able to obtain in conducting the scan of programs/services/supports across the 8 counties of WNY. Those who participated in the scan represent a sample of programs/services/supports available in WNY and therefore the findings are limited to their input; extensive but not exhaustive.





Scan Findings



Scan Findings

The following is a synthesis of scan interview data. We offer some representative quotes for questions asked of participants. For more illustrative quotes, please see Appendix A.

Who are the clients?

The demographics of the individuals served by the agencies interviewed for the scan reflect the social and economic challenges of WNY. The vast majority reported working with families living in poverty, many of which live in single parent households, and are struggling with domestic violence and or substance use disorders. Very few agencies reported specific accounting for the numbers of mothers and young children served with regard to trauma. If an agency reported working with children under the age of 5 years of age, intervention or support was only provided in the family context. A large proportion of agencies in the sample reported working with children over the age of 5 with a family focus or working with women or parents independent of their young children when addressing trauma. It is important to note that no demographics or statistics were reported specific to trauma related work with mothers and children under the age of 5. If agencies reported working with mothers and young children it was generally in the capacity of domestic violence, housing, or supervised living. Agency representatives report that they are serving women of childbearing age, who are typically those with sociodemographic risk factors, including those with very low income, are often single-headed households. The families that come to the attention of agencies may be struggling with substance use, dealing with crises of various sorts, or are identified because of child protection service involvement. By and large, although agencies are serving pregnant women and those with infants and toddlers, they are not necessarily tracking them specifically.

■ “Our folks are usually lower SES. They live crisis to crisis in a sense of the poverty.”

■ “75% of clients are insured through Medicaid.”

Highlights of agency client demographics. Families served by agencies in our scan were often:

- Living in poverty
- From single parent households
- Dealing with crises like substance abuse, domestic violence, and child abuse
- May not enter services until such crises come to the attention of child protection or law enforcement



How do agencies define trauma? Have they received trauma-informed training?

In order to contextualize engagement with trauma-informed care and trauma-specific interventions, we first inquired whether agencies have a working definition or shared understanding of trauma in the lives of the clients they serve. There was considerable variation in how agencies define trauma, with the vast majority of respondents indicating that they did not have an agency-level working definition of trauma, or stating that if there was one, they could not recall it. One respondent offered this agency definition of trauma:

“Things that overwhelm a person’s ability to cope such as an event that shakes their sense of safety in the world, often leaving them vulnerable and leads to medical and emotional problems. “

Although there were few who reported agency-level working definitions of trauma, several respondents did provide what they perceived as a shared understanding of trauma and how it effects clients’ lives. These ranged from statements that globally defined trauma and how it affects people to delineation of types of traumas that are often seen. Global definitions of trauma included:

“(...) they don’t have a definition of trauma, but her understanding of trauma is that it’s an event that impacts someone’s life in a negative way.”

“Whenever a person has a life adverse experience that impairs their ability to function.”

“I would say that it’s somebody whose experienced an unhealthy or painful life experience. Often it can be somebody who has been diagnosed with PTSD.”

Some respondents defined trauma by delineating the type of exposure more specifically. This was typically accordant with the type of agency and its service mandate, for example, a child advocacy center’s definition of trauma might include child sexual and physical abuse as part of their shared understanding of trauma. Regardless of how agencies define trauma, many respondents expressed that their agencies recognized the impact of trauma on mothers and young children, with about one third reporting having participated in some sort of training on trauma-informed care (TIC), and some agencies offering that they do trauma assessments or assess for adverse childhood experiences. Some reported periodic engagement with webinars or conferences or continuing education offerings on trauma. University at Buffalo’s Institute for Trauma and Trauma-Informed Care (ITTIC) was the most frequently noted source of trauma-informed care training for personnel.



A few respondents defined their agencies as trauma-informed (weaving trauma informed principles and focus throughout policies and procedures in the agency):

“We are a trauma-informed agency. We’re looking at the perspective of any sort of loss, traumatic loss, any grieving, medical issues, the whole amount of storms down through.”

Several agency representatives expressed issues related to application of TIC and translating understanding of trauma to the provision of trauma-specific services:

“A lot of people understand what TIC is, but do not know how to APPLY.”

There was considerable variation in how agencies define trauma, with the vast majority of respondents indicating that they did not have an agency-level working definition of trauma (or could not recall it). Some offered ad hoc “global” definitions of trauma, and some defined trauma more narrowly as accordant with the type of services they provided (child abuse, domestic violence). In fact, many agency representatives made the assumption that we when we were asking about trauma in regards to mothers and babies, that we were in fact asking about domestic violence exclusively. Regardless of how respondents defined trauma, many expressed that their agencies recognized the impact of trauma on mothers and young children, and reported having participated in some sort of training on trauma-informed care (TIC). A few respondents went beyond describing episodic participation in trauma and trauma-informed trainings and defined their agencies as “being” trauma-informed.

Highlights of agency definitions of trauma and experience with trauma-informed care. These include:

- › By and large, agencies do not have a universal working definition of trauma
- › Trauma is often narrowly defined as that which is accordant with the services the agency provides
- › Many assume that the effects of trauma in the lives of mothers and babies centers on domestic violence exclusively
- › Many agencies have sought some sort of training on trauma and/or trauma-informed care
- › Few defined their agencies as “trauma-informed”
- › Several expressed concern about there not being accompanying access to trauma-specific interventions and training on how to apply trauma-informed understandings. This suggests that many may subsequently feel “all dressed up with nowhere to go.”



What trauma-specific services are available for mothers and young children?

The most frequently cited trauma-related services for women and children included support for victims of domestic violence (which variously included provision of shelter, transitional housing, counseling, parenting groups, education & training, economic empowerment), rape crisis and Sexual Assault Nurse Examiner (SANE) programs (Campbell et al., 2014), and support for child victims of physical and sexual abuse through the Child Advocacy Center model (including forensic interviewing, child therapy, and case management; Herbert & Bromfield, 2016). Some agencies also reported employing clinicians trained in the use of trauma-specific interventions. The use of Trauma-Focused Cognitive Behavioral Therapy (TF-CBT; Cohen, Mannarino, & Deblinger, 2006) was reported by eight agencies, use of Eye Movement Desensitization and Reprocessing (EMDR; Shapiro & Forrest, 2016) was reported by seven agencies, and use of Progressive Counting (Greenwald & Schmitt, 2010) was reported by four agencies.

(...) they basically have no specific trauma services for moms/babies. They do groups for women around addiction. Some will incidentally be pregnant.

Although many services are available for women and children in general across the eight counties, including early childhood education, child protective services, substance use treatments, and parenting classes and supports, these are not specifically focused on trauma prevention or recovery. Importantly, we found no evidence that the available trauma-specific offerings were specifically targeted to mothers and children under the age of five. It is also noteworthy that the majority of the available services appear to be largely reactive in nature, rather than preventative, typically responsive to acute crisis situations.

Highlights of trauma-specific services available for mothers and young children.

These include:

- There are several trauma-related services providing a response to crises of domestic violence, rape, and child abuse in western and central New York.
- Some clinicians are using trauma-specific interventions in mental health settings.
- Trauma-specific services and interventions do not appear to be targeted to mothers and young children.
- Services are largely responsive rather than preventative in nature.



How are agencies funded?

A multitude of funding sources were reported, with large organizations largely functioning through a combination of health insurance reimbursement and county, state, and federal grant funding. The majority of agencies reported relying on a diversity of funding mechanisms. A complete list of funders mentioned by agencies can be found in Appendix A.

It is clear that agencies invest a great deal of time and resources in the efforts required to procure funding for their activities. Some reported that they partnered with other agencies to secure funding, and maintained memoranda of understanding with partner agencies to delineate provision and coordination of services. Funding streams run the gamut from federal funding to grass-roots local efforts such as thrift store proceeds, letter writing appeals, and community fundraising events.

Highlights of agency funding sources. Agencies in Western and Central New York who provide services to mothers and their babies:

- Spend significant amount of time and effort to procure funding
- Are reliant on a multitude of funding streams including federal, state, county, and local sources
- Are partnering with other agencies when possible to secure funding

How is assessment, outcomes & evaluation handled in agencies?

With regard to trauma, a number of agencies indicated using the Adverse Childhood Experiences (ACE) as a screening tool. By and large, evaluation was spoken of broadly, not specific to trauma related objectives or population specific, and was often limited to client satisfaction.

■ “Evaluation is difficult. They do surveys when they complete the program.”

Many agencies indicated currently tracking services provided and/or engaging in pre post measures of specific efforts. In addition, many among the sample expressed efforts to improve evaluation while few reported having capacity and processes in place for sophisticated evaluation. Specific to trauma, one agency spoke of evaluation with regard to trauma-informed care among their staff. Although some agencies are utilizing the ACE screening tool as a stand-in for trauma screening, it is not clear that this is being done on a regular basis across agency settings. Evaluation itself appeared to be limited by a number of constraints, and typically involved client tracking and client satisfaction ratings upon exiting services.



Highlights of agency assessment, outcomes, and evaluation. These include:

- › Assessment for trauma was not necessarily routine.
- › The ACE as a screening tool was reported as being used by some agencies.
- › Outcomes related to reducing the burden of trauma for mothers and young babies/toddlers was not mentioned.
- › Evaluation typically centered on client tracking and satisfaction surveys

To what extent do agencies partner with other agencies to deliver trauma-related services?

Every agency representative spoke of making some referrals to other agencies, and fewer specific trauma-related partnerships were mentioned. Often, these referrals were focused on addressing social determinants of health (housing, social services, etc.) rather than trauma-specific treatment. Some of the referrals were systematic, some were situation-specific, and some appeared “patchwork” in nature.

“We work with a lot of other agencies in the community, we’ll refer people to a lot of different places depending on what their needs are.”

Agencies whose directive is to work directly with trauma, such as Child Advocacy Centers, domestic violence shelters and programs, and family courts appear to have the most “ready” network of referral partnerships in addition to their own in-house trauma treatments. In contrast, other agencies providing mental health services and support for sociodemographic disadvantages appear to be reliant on more ad hoc referral networks. Importantly, the majority of trauma-related referrals were not necessarily focused on the perinatal period.

Highlights of partnering arrangements with other agencies to deliver trauma-related services. These include:

- › Those who focused on trauma already were more likely to know about other trauma-related services and maintain partnering relationships.
- › Those agencies not already focused on trauma and its treatment appear to rely on less formal referral resources.
- › Trauma-related and childbearing-specific referral streams are limited.
- › Referrals for trauma-related services were generally not focused on the perinatal period.



What programs are under development?

Respondents shared information regarding services, interventions or supports that their agencies are currently developing. About one third of respondents articulated efforts underway to improve trauma-focused services, and increase service offerings in general. A complete list of programs under development mentioned by the respondents can be found in Appendix A.

Several agencies appear to be in the process of building capacity for service delivery in general and for increasing mental health offerings more generally. Some are trying to seek trauma-informed training and/or increase availability of trauma-related services. Some of these efforts are potentially (but not expressly) directed toward mothers and babies/young children, including parenting programs and support groups, and foster parent trauma training.

Highlights of programs under development. These include:

- Agencies are working toward increasing trauma-related services
- A few of these are specifically directed toward mothers and babies/young children:
 - Parenting programs & support groups
 - Foster parent trauma training

What former programs have been discontinued?

Agencies acknowledged letting go of programs due to lack of funding or adequate supervision. Quotes pertaining to discontinued programs can be found in Appendix A.

Unfortunately, several of the programs agencies once offered but are not longer able to do so are those that were geared toward trauma survivors. Although there were no discontinued programs directed specifically toward the population of childbearing women, several programs, like kinship care, respite care, and counseling for domestic violence, would likely still be of benefit to childbearing women and young children if they were still in existence.

Highlights of former programs discontinued. These include:

- Kinship care
- Respite care
- Counseling for domestic violence
- Prevention education



- › Supervision for the trauma treatment Progressive Counting
- › Programs were discontinued for lack of funding or for reallocation of services to other agencies

What are current challenges agencies face in the provision of services?

A multitude of challenges are experienced by the agencies. By far the most frequently cited challenge reported is lack of necessary funding followed by the direct effect lack of funding has on staffing and capacity of agencies to deliver services:

“More funding, more availability of programs within the county. More professional people within the county—like, people who provide services aren’t moving into the area.”

“The bullseye is the funding piece...impacts staffing ratios to clients as well as stress. Agency is really good at getting ahead on the curve. Learning curve for staff around the new E-Record system.”

Another challenge reported by respondents is an apparent lack of collaboration across agencies:

“At capacity all the time. Long waiting list. Kids are dumped by primary care physicians—anything beyond minimal psychiatric needs and the kids are handed off and the docs won’t take them back. In other words, struggle to have episodes of care where agency helps to stabilize the kid and then primary takes kid back into care for maintenance.”

Respondents also noted the lack of awareness of trauma-informed care and the relative lack of trauma-specific services, as well as a lack of uniformity in the application of trauma-informed care principles. The role of stigma was also mentioned as a persistent challenge to service provision.

An additional concern, and one which is quite important for our population of interest, is the perception that services have shifted away from a focus on infants in favor of toddlers:

“Funding. A long time ago we had parent child center for parents to transition into early head start. Used to have a prenatal program in 96. We had early headstart prenatal services until 2005. Funding got tighter, so had to look at ways to serve largest population. Service got shifted more toward toddlers rather than prenatal. One of the programs that people miss the most.”



Overall, agency representative concerns run the gamut from lack of funding and lack of capacity to meet the demand for services to interprofessional collaboration concerns, and concern for addressing stigma that limits treatment engagement. Agencies may also feel challenged in implementing a trauma informed lens and, specific to our key population, have experienced a shift in focus of services away from prenatal to children 3 and up.

Highlights of current challenges faced by agencies. These include:

- Funding is the most frequently cited concern
- Limited funding puts stress on service provision
- More interprofessional collaboration is desired
- More support to translate trauma-informed care and increase trauma services is desired
- Stigma is a challenge in service provision and uptake of services
- The perinatal period and infancy appear to be less of a current focus in terms of funding availability

What do service providers see as pressing needs of mothers and young children?

■ “Care is fractured.”

When asked about what they perceive as the pressing needs of mothers and young children in their community, participating agencies spoke of systemic issues including lack of services geared toward this population (treatment gaps), a fractured system of care and a lack of coordination of services, and a lack of access to the limited services available. Many emphasized that the pressing issue of substance use disorders, particularly opioids, which are affecting all populations seeking treatment, and discussed the role of stigma around both mental health and substance use. Equally as important, agencies also spoke of barriers to treatment engagement due to basic social determinants of health such as housing and transportation. Agencies also recognized the cycles of poverty, violence, and vulnerability in the families they are working with and often commented on the stigmatized nature of treatment and support, particularly related to substance use.



Treatment gaps were noted by respondents, including for care during the perinatal period, for toddlers ages 3 and 4, for single mothers, refugee mothers, at-risk youth, for parenting support, and support for court-involved families:

“Data in Allegany County suggests late term introduction to OBGYN services. Not seeing strong prenatal care or getting first trimester care.”

“(...) there’s a noticeable gap between early intervention through DSS. They can work with kids until 3, any other case managers don’t work with kids until the age of 5. She feels there’s a big gap in services available to 3 and 4 year olds.”

“Parenting skills is a consistent need for populations. They are addressing it in program, but because of the trauma history there is a greater need for parenting education.”

Fractured or uncoordinated care was noted by several respondents in relation to providing services for mothers and babies. Several also underscored how a lack of trauma-informed care and trauma-responsiveness contributes to this sense of care being fractured:

“The state of women focused care is abhorrent. (We) wish to have parenting supports, perinatal supports. There are not near enough postpartum supports; not near enough comprehensive psychiatric treatment available for postpartum women; Need to train clinical staff in perinatal mental health.”

A lack of access to needed services was articulated by respondents, specifically regarding domestic violence, rape, early childcare and parenting support, and substance use treatment.

Structural factors and economic system realities consistent with social determinants of health framework were frequently cited. These included lack of housing support, including for emergency housing and long-term housing, and a lack of transportation to and from services:

“Housing. I think that for a lot of our parents the unmet needs are really fundamental non-medical needs. Everything; not having a car that won’t break down, car seat, diapers, people are struggling. People you would not even expect. Utilities.”

“Transportation—lack of access. Services aren’t available in the county.”



In addition to pressing needs like lack of services, or the ability to access them, respondents identified further structural issues related to the provision of care. Provision-related issues included processes that were potentially stigmatizing and effectively denied care to those who most needed it:

“The process itself can be better—intake forms and procedures for some programs are stigmatizing and retraumatizing. For example, the Health Homes (HARP) ask individuals in the intake forms to go into grave detail about past traumatic events and provide “proof” of such an event. The process was dissuading potential clients away from applying to the program due to the invasive intake process.”

A final, important pressing need identified by respondents is the need for a greater recognition among care providers regarding cycles of violence and subsequent psychiatric and other vulnerability:

“Keeping families together. We do not reunite families often enough. Don’t think about the trauma inflicted on a family by removing kids.”

Highlights of respondents’ assessment of the pressing needs of mothers and babies in the eight-county region. These were far ranging and included:

- › Treatment gaps exist for services for single mothers, infants, toddlers, refugee mothers, court-involved families.
- › There is a perception that care is fractured and uncoordinated in relation to trauma
- › There is a lack of access for early child and parenting support.
- › There are limitations in access to substance use treatment.
- › Housing and transportation are cited as particularly pressing issues.
- › Provision of care is often stigmatizing and has the effect of denying care to those who most need it.
- › There is a need for a greater recognition among care providers as to cycles of violence and vulnerability.





Discussion



As evidenced by the scan results, there are a great number of agencies working to support families and meet the emotional, social, and economic needs of the most vulnerable across the eight counties of Western NY. There are several trauma-specific and crisis-responsive services in place for women and children in the eight county region, including domestic violence shelters and services, rape crisis and SANE programs, and services and support for child victims of abuse, such as child advocacy centers (CACs) and Child Protective Services. Many agencies are engaged in training in trauma-informed care; and many are obtaining such assistance from University at Buffalo's Institute for Trauma and Trauma-Informed Care (ITTIC). Several agencies are training clinicians in trauma-specific interventions, as well, including TF-CBT (Cohen, Mannarino, & Deblinger, 2006), EMDR (Shapiro & Forrest, 2016), and Progressive Counting (Greenwald & Schmitt, 2010). Additionally, one agency reported using Trauma Systems Therapy (Brown, McCauley, Navalta, & Saxe, 2013); another reported the use of Dialectical Behavioral Therapy (DBT; Linehan, 1987).

In addition to trauma-responsiveness, some agencies are engaged in proactive, preventative efforts to encourage positive mother-infant relationships, including parenting support through classes and groups. One agency reported a more direct form of parenting relationship support using Parent-Child Interaction Therapy (PCIT). Interviews with representatives of all of these agencies were characterized by deep concern for the clients served, expressions of regret for the limitations of services and programs they can offer due to budgetary and staffing restraints, and an eagerness to learn more and do more toward addressing trauma-related needs of women and their children in the community.

Despite such thoughtful and diligent efforts by the multitude of agencies we interviewed, the overall results illustrate that we, as a community of service, are still reaching for ways to better support, nurture, and bolster individuals and families, particularly around trauma. Although there is a growing recognition of the impact of trauma on the health and wellbeing of individuals and families, demonstrated by several agencies involved in the scan reporting on-going dialogue within their agencies about trauma, the landscape in WNY around trauma support and services for mothers and young children is complicated. The data made clear that there is no uniform definition of trauma across the region and that, while a select few agencies reported having a "hard-wired" definition of trauma within their agency and report engaging trauma-informed principles across their agency, the majority of respondents do not. More specifically, a narrow view of trauma was common. For example, when asked about trauma or trauma related services, many agencies responded with specific services and supports for survivors of domestic violence or for current child abuse. Beyond these crisis-responsive services, there appears to be a lack of general knowledge around what trauma is more broadly, and subsequently



there is a shortage of services that are trauma-informed and trauma-focused. Specific to the population of focus for our scan, mothers and children under age 5, the data also made clear that there is very little focus, broadly speaking, on the perinatal and antenatal periods, or early mothering, and consequently little addressing trauma-related sequelae of vulnerable new families.



Pregnancy and early parenthood are opportune times to engage families. Families in this season of life are often more engaged in health care due to prenatal visits, and among women living in poverty, more likely to be engaged with social services such as WIC (Women, Infants and Children) and SNAP (Supplemental Nutrition Assistance Program) than at other times in their lives. Pregnant women may be more receptive to change patterns of behavior in hopes to create a better life for their child (Hall & van Teijlingen, 2006). As it stands,

we are failing to capitalize on the opportunity presented by pregnancy and early parenthood in WNY generally speaking and, based upon findings from the scan; we are woefully inadequate with regard to trauma-related services and supports for mothers and young children. Despite considerable effort across counties, the data illustrate a fractured care system with reports of insufficient collaboration and integrative care, often leaving families strapped with the burden of seeking services through multiple agencies—for example, isolating treatment services for substance use, mental health, and social services—with arguably the heaviest burden carried by single mothers, infants, toddlers, refugee mothers, and court-involved families.

Setting these findings in the context of the pervasive and taxing nature of poverty helps us to understand the dire need for prevention and intervention efforts around trauma for mothers and young children. One of the greatest challenges in this region, and in many across the country, is the pervasiveness of poverty, particularly among children. With poverty rates over 50% among children in the City of Buffalo, and hovering around 31% in Erie, Cattaraugus, and Chautauqua Counties for children under the age of 6 ([U.S. Census, 2017](#)), agencies are overwhelmed by the complexity of circumstances and needs of families. Children's health and wellbeing, especially under the age of 5, is completely dependent on the environment in which they are being cared for. Stark figures of poverty among children in our communities are simply a manifestation of the plight of mothers, fathers, siblings, grandparents, and other caregivers living in conditions of scarcity. In the words of Donald Winnicott (1947), a well-known English pediatrician, “there is no such thing as a baby...if you set out to describe a baby, you will find you are describing a baby and someone.”

This conceptualization of a child's health and wellbeing as inextricably tied to the health and wellbeing of her caregiver's, as the quote suggests, calls on us as service providers to care for the unit rather than isolating the mother and/or the child from



her/his environment. The tendency to treat mother and child as two separate entities and the general failure to recognize the integral role of emotional and psychosocial factors in health in wellbeing is captured in a quote from a scan participant regarding a conversation she had with OBGYN who said “we only treat women from the neck down.” Not only do we tend to neglect, or worse yet separate mind from body, we tend to engage in care with a mother as though she is simply a vessel for the child, failing to recognize the importance of the parent/infant dyad, the centrality of this social relationship, and the mental health and well-being of the pair.

Setting our findings in the context of poverty also calls on us as a community of service to understand the poverty’s threat to safety and stability for all living within its grip. In short, poverty breeds vulnerability. One example of this is the link that has been empirically drawn between income and school readiness (discussed in detail in the literature review). Using birth cohort data from the Early Childhood Longitudinal Study, researchers from the Brookings Institute (Isaacs & Mangunson, 2011) found that household income and school readiness are linked. Such findings expand upon much earlier work conducted by Duncan, Brooks-Gunn, Yeung, & Smith (1998) who, using data from the Panel Study of Income Dynamics data, suggested that family economic conditions are a determinant of school achievement, particularly among families of low income; effectively setting the academic trajectory which ripples throughout adulthood and subsequent generations. These data encourage us to think about a child’s readiness for school as potential products of the consequences of poverty experienced by the family, or as Ideas42 authors Daminger, Hayes, Barrows, & Wright (2015) puts it, the consequences of chronic scarcity, and move away from the blaming of individual parents for not readying their child for school.

Chronic scarcity plagues the people served by the agencies of Western New York, the agencies themselves, and those who are arguably most in need, those who cannot access needed services. Many agencies spoke of the significant challenges experienced by those that they serve and those they cannot reach, challenges including available and affordable housing. One agency spoke of a number of clients who sought services related to domestic violence that had to return home to the perpetrator because there was no housing available for them to find sanctuary in. Transportation was also a common challenge reported by agencies in serving clients regarding trauma or otherwise, particularly in rural communities. Services may be available in one’s county, but they may not be accessible. The findings regarding housing and transportation in the scan are by no means new information but serve to highlight the challenges and threats to basic social determinants of health and wellbeing: shelter, safety, connection to services, etc.

Chronic scarcity is clearly not limited to economics. It extends to physical and emotional health, social capital, education and more, leaving individuals and the agencies that serve the in a reactionary position. In other words we are collectively



stuck downstream. As one participant said, “We have become an emergency room. The bulk of our work is focused on safety and stabilization—we don’t get to move past safety and stabilization—basic Maslow’s hierarchy of needs.” This downstream position is understandable in the face of pervasive poverty and its far-reaching tentacles across the lifespan. It is well established that the ramifications of living in circumstances of poverty increases one’s vulnerability in many forms - lower academic achievement (Isaacs & Mungunson, 2011), poor health outcomes (National Center for Health Statistics, 2016), and traumatic experiences (Sedlak et al., 2010), just to name a few. The downstream position of services and programs for mothers and young children is also true when it comes to trauma. Recognition and trauma treatment is most often initiated when a major problem is identified with children in school or when people have come to the attention of service providers due to a crisis, such as substance use and domestic violence, or when child protection or courts are involved.

The reactive rather than proactive position of most of the agencies we spoke with may be in part due to internal hardships, such as lack of funding and/or capacity. Programs and opportunities have been lost as a result of funding cuts or loss of qualified staff, often leaving mothers and young children without services or held in ever growing waitlists for remaining services. This is most unfortunate because, as mentioned earlier, pregnancy and young parenthood are documented windows of opportunity that are rendered useless due to lack of services or extensive waitlists. Not only does the missed opportunity have immediate consequences to mom and baby, it is a missed opportunity for improving health and wellbeing across the lifespan for both mom and baby.



Intervening “upstream” in the perinatal period holds promise and potential not only for addressing individuals, but also for changing trajectories of health, well-being, and academic success for generations. As Winnicott’s quote suggests, “there is no such thing as a baby”. **A baby is the product of her mother and father, her grandmothers, her great grandfathers...** She is a product of the intergenerational compilation of her ancestors lived experiences, the political and economic circumstances of their time, and their emotional and physical health. If mom is living in conditions of chronic

scarcity, her body is likely responding physiologically with stress. Chronic stress, in the form of trauma, poverty conditions, and the like, have been shown to influence fetal development (Lu, Kotelchuck, Hogan, Jones, Wright, and Halfon, 2010). Sustained high levels of maternal stress have been associated with premature



birth and low birth weight infants (Matthews & Phillips, 2010). In addition, early exposure to perinatal stress and the subsequent programming of the fetal response to stress sets the stage for poor health outcomes such as hypertension and cardiovascular disease for the child across his or her lifespan (Lu et al., 2010); thus adding to the cycle of physical vulnerability. We also have come to understand the pervasive consequences of trauma, brought to light by the groundbreaking Adverse Childhood Experiences (ACE) study, which found that the greater the number of adverse experiences in childhood, the greater the likelihood of adverse health outcomes in adulthood including alcoholism, drug abuse, suicide attempt, smoking, and heart disease (Felitti et al., 1998); thus contributing to the cycle of psychological vulnerability.

Limitations.

The authors of this report engage with the realities of poverty and trauma as practitioners, educators, researchers, and advocates. We navigate with an understanding of poverty as conditions of chronic scarcity and the behavioral consequences of such social, political, environmental, and economic conditions that create such scarcity, and a trauma-informed lens that looks at the ramifications of trauma that were inflicted on an individual, functioning from a place that asks, “what happened to you?” rather than “what is wrong with you?” We allow the data to speak its truths, however, we digest it with the aforementioned lenses.

This scan has limitations beyond the theoretical orientation of its authors. First and foremost, despite our attempt to be exhaustive in our scan, the participation in the scan does not represent the entirety of the work being done in the agencies and programs across the 8 counties of WNY, limiting our results to only those we were able to reach. In the same vein, we as a team found it difficult to connect with agency staff or administrators who could speak to the demographics, programming, needs, etc. specific to mothers and children under the age of 5; most calls were fielded by an agency receptionist and few agencies have dedicated programs for this population. In addition, the information we did receive from participating agencies was dependent on the vantage point of the person who agreed to be interviewed. We assume that an agency administrator and a frontline clinical staff member may have different perceptions of both the questions asked and



the needs and challenges of mothers and young children they serve. However, these representatives are not the final authority on the experiences of low-income mothers and children in the region. It is an imperative as a next step to hear directly from the mothers and young children in our communities to gain a definition and understanding of trauma and priority needs that is rooted in first-hand accounts of lived experience.



It is also important to note that the body of literature regarding trauma and maternal and child health has not sufficiently accounted for the social, structural, political and economic forces that press particularly on people of color. These structural inequities are likely latent variables in the toxic mix of trauma and poverty that cannot be accounted for by this scan.

Implications and Recommendations

We have identified many areas that need addressing when it comes to provision of services for mothers and babies as it pertains to trauma in Western New York. Now we will shift attention to highlighting recommendations for filling identified gaps in trauma-related services and treatments that hold promise for addressing intergenerational cycles of violence and psychiatric vulnerability. We will also suggest ways to begin addressing concurrent intergenerational cycles of poverty and sociodemographic disadvantage, while considering the feasibility of such efforts in the current political climate that is threatening Medicaid- the single largest health insurance for the very population we hope to serve.

Our overarching recommendation is to capitalize on the opportunity that is the perinatal period, broadly speaking. This is not limited to adding an additional service to an agency but requires a collective move “upstream” through thoughtful and coordinated efforts ranging from macro to micro; from creating an environment that is supportive and responsive to mother and baby’s needs through policies to personalized clinical supports of the mother/baby dyad.

Specific to trauma, a recommendation that capitalizes on the uptick in utilization of existing services for expectant mothers or new mothers and young children is universal screening for trauma of all expectant mothers. This can be accomplished by using a simple tool such as the [ACE: Adverse Childhood Event checklist](#) (there are many versions available) or a multitude of other measures including the [Trauma History Screen \(THS\)](#). Where possible, allowing women to speak about their histories rather than being bound to a series of yes or no answers is advisable, as checklists do not often allow space for individuals to indicate the severity or meaning of the adverse event or series of events that they are carrying with them into their pregnancy. Universal screening of all expectant mothers first and foremost would



allow for identification of women who may be in need of additional supports and open a door to access such support through referrals. Secondly, universal screening



for adverse childhood events and histories of trauma among pregnant women will shed light on the true prevalence of trauma in the lives of those living and raising families our communities. Pairing universal screening with streamlined, aggregated (de-identified) data collection system of the demographics, screening results, and the resulting referrals would also help to illuminate who, how many, and what kind of help is being utilized and what is missing from the services and supports across the region. Additionally

such streamlined concrete numbers may help to draw in funding for collaboration across the region for local agencies to better meet the needs of mothers and young families specific to trauma. In the same vein, evaluation of services and programs specific to trauma among this key population and beyond is also needed. The scan indicated that few agencies are equipped to evaluate their programs, leaving them limited to simple client satisfaction surveys. While satisfaction with clinicians and services are important, they cannot speak to the effectiveness of a given intervention or program, nor can it help to obtain grant funding. Funding for in-house evaluation capacity building or for fostering partnerships with external, independent evaluators is recommended.

Another central recommendation is to move toward more integrative care models in WNY. It is rare that an individual living in conditions of chronic scarcity is contending with one concern and it is rare if not unheard of that an individual is meeting that concern with only one dimension of their past or present physical, emotional, social, spiritual, self. True integrative care surrounds an individual and their family with a holistic embrace of supports and services. Integrative care is best described by Bell and colleagues (2002):

“...combination medicine (complementary and alternative medicine (CAM) added to conventional) is not integrative. Integrative medicine represents a higher-order...systems of care that emphasizes wellness and healing of the entire person (bio-psycho-social-spiritual dimensions) as primary goals, drawing on both conventional and CAM approaches in the context of a supportive and effective physician-patient relationship.”—p. 133

Two themes that emerged from the data in this scan were fractured care and insufficient collaborations/partnerships. Moving towards integrated care models would help to remedy these issues in our care landscape for mothers and young children, and for all others engaged in care.



A tangible example of integrated care is that of the hospice care model—a model of care reserved for those at the end of life. Hospice is a Medicare/Medicaid covered benefit for those determined terminally ill and it includes a wide-range of services for both the patient and the patient’s family. According to the [Medicaid.gov website](https://www.Medicaid.gov), services include: “nursing, medical social services” (which includes social work and chaplain/spiritual services), “physician services, counseling services to the terminally ill individual and the family members or others caring for the individual at home, short-term inpatient care, medical appliances and supplies, home health aide and homemaker services, physical therapy, occupational therapy and speech-language pathology services”. In truth, this is a beautiful conglomeration of services that aim to meet the bio-psycho-social-spiritual dimensions of which Bell and colleagues (2002) were speaking. The question most certainly is not why do families with a loved one at the end of life receive a spectrum of integrated services; it is why



don’t families at the beginning of life receive the same? With evidence continuing to mount about the integral and sensitive time period of pregnancy and new parenthood, and the significance of early childhood circumstances on the life trajectory of a child and critical role of the mother in the child’s social and emotional development in those early years, why don’t we offer up such holistic and accessible supports? It is our recommendation that we apply a hospice model of care to pregnancy, birth, and early childhood/parenthood.

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While application of a hospice model of care to the beginning of family life may seem too great a task, there is movement across New York State and here in Western New York towards integrative care. One example of this can be observed in the evolution of [Medicaid Health Homes](#). Health homes are designed for those enrolled in Medicaid who have a chronic condition. Different from a hospice model, health homes use a care management service model whereby the patient is assigned a care manager who oversees all needed care and helps the patient/family to navigate the care system. Within Health Homes, all care providers communicate with one another and health records are shared. Interestingly, one chronic condition that [determines eligibility in New York State for a child Health home is complex trauma](#). With Medicaid redesign well underway and regular threats to reduce Medicaid



spending, it remains to be seen whether Health Homes will persist, let alone grow, but it is a noteworthy effort of integrated care nonetheless. Applying a model of Health Homes to pregnancy care, which is also a benefit covered under Medicaid for those in low-income circumstances, may help both mom and baby to thrive in their early years together, particularly if mental health services are fully integrated.

On a smaller scale, we would like to highlight a local program that is working to integrate care through co-location of services, [Community Action Organization \(CAO\) of Erie County's, Head Start](#). CAO Head Start has taken steps to infuse their policies and procedures with trauma-informed principles and is currently collaborating with the [Child and Adolescent Treatment Services \(CATS\)](#) to provide social workers and licensed mental health workers within the Head Start locations across Erie County to better serve the children and their parents, including in coping with the past or present traumatic events and ramifications thereof.

The preceding recommendations: focusing on the perinatal period, universal screening for trauma/collection of screenings, and pushing toward truly integrative care and coordination for mothers and young children, all require *further development of trauma-specific programs and interventions* in western New York. These should include efforts aimed at multiple levels, including those encompassing *universal prevention, targeted interventions and treatments, and adapted interventions*.

Universal prevention efforts should be strengthened in Western New York. As mentioned previously, there is a preponderance of evidence indicating that *perinatal home-visiting programs* such as the Nurse Family Partnership are able to provide continuity of care and improve maternal mental health and child development (e.g., Olds, 2006; Olds et al., 2010). A [Nurse Family Partnership](#) program is already underway through the Catholic Health system in Chautauqua County, supported by funding through Medicaid DSRIP (Delivery System Reform Incentive Payment). [The Catholic Health website](#) indicates that they will be extending this program to Erie County, as well. Although the Nurse-Family Partnership does not specifically address a mother's trauma history and its sequelae, it does have the mother's and child's health and well-being as central goals, together with improving parental care of the child, and has demonstrated effectiveness at preventing child abuse and neglect (Olds, 2007; 2008).



There are other programs with home-visiting components available in western New York, which are also funded by DSRIP through the [New York State Department of Health](#) (see for an online listing and search of programs). There are five types of home-visiting programs available in New York State; these include the Nurse-Family Partnership and also [Early Head Start](#), [Healthy Families New York](#), [Home Instruction for Parents of Preschool](#)



[Youngsters \(HIPPY\)](#), and [Parents as Teachers](#). Of these home-visiting programs it should be noted that the primary focus is on promoting healthy child development across multiple domains, and are not focused specifically on addressing trauma or disrupting intergenerational cycles of violence and vulnerability (although both Nurse-Family Partnership and HIPPY do list prevention of child abuse and neglect as goals). A quick perusal of home-visiting services available in the eight county region of Western New York shows that Early Head Start is available in seven of the eight counties (all but Niagara; with Genesee and Orleans sharing services), Healthy Families is available in half of the counties (Cattaraugus, Erie, Niagara, & Allegany), Nurse-Family is available in Chautauqua and (soon to be in) Erie counties, and HIPPY and Parents as Teachers are not available in any of the counties. There are no home-visiting programs available of any sort in Genesee County, other than the shared Early Head Start services with Allegany County.



Home-visiting is also a main feature of the infant mental health approach identified earlier as a universal approach salient to addressing intergenerational cycles of vulnerability. However, this universal approach focuses not only on infant development but is primarily concerned with the developing relationship between the parent/caregiver and the infant/child and the promotion of secure attachment. Birthed in Michigan, the Infant Mental Health movement has spread across the United States and the globe. Selma Fraiberg's original model of delivering "kitchen table therapy" (Sternin, & Weiss, 2014) has evolved into a system of provider education and certification first codified by the [Michigan Association for Infant Mental Health \(Mi-AIMH\)](#). The Michigan model of Infant Mental Health (IMH) has served as a model for similar associations in over 20 states as well as the international [World Association for Infant Mental Health \(WAIMH\)](#) and Mi-AIMH has licensed the use of its competency guidelines to these sister associations. The [New York State Association of Infant Mental Health \(NYS AIMH\)](#) was founded in 2015, and has begun instituting the Michigan model for education and endorsement. The process of scaling up NYSAIMH to train infant mental health professionals in NY state is underway, however, as of this writing infant mental health services are not available in western New York. Based on the results of this scan, bringing infant mental health services to Western New York would provide a universal approach with real promise to directly address the "ghosts in the nursery" in the form of unresolved trauma that plagues women as they become parents.

Parent education and support in general, whether through guidance offered as part of a home-visiting program, or through interactions with personnel at a Head Start/Early Head Start facility, is another example of universal prevention that should be maintained and strengthened in WNY. Several agencies shared that they



had some sort of parenting focus, either through facilitation of a support group of some sort (e.g., for parents in substance use recovery, or parenting in context of domestic violence, foster care parent trauma training) or through a particular parenting program (e.g., [Parenting the Love and Logic Way](#), [Nurturing Parent, Incredible Years](#)). One agency, Main Pediatrics, has begun delivering the parenting program [Healthy Steps](#), which provides parenting support and referral to resources. However, several agencies also expressed a desire for more in the way of practical support for parenting, and mentioned that some of these practical supports, like kinship care support, and respite care, are among programs no longer being offered due to budgetary constraints. A desire for more support for parents in relation to addressing trauma was also articulated by agency representatives, and it is our recommendation that more could be done in this area for families in WNY.

It is important to note that universal approaches to addressing trauma, as well as trauma-specific interventions and treatments, are all predicated on advancing clinician education. Although clinicians interviewed for this scan express appropriate concern for mothers and their infants/children in regards to crisis responsiveness (i.e., domestic violence, disclosures of child abuse/neglect), it is unclear how



aware they are of the literature surrounding the effects of past trauma and adversity on the childbearing year, and whether they are able to recognize the need for application of a trauma-informed lens to the perinatal period, and whether they can articulate how intergenerational patterns of violence and psychiatric vulnerability are perpetuated. It is also unclear whether clinicians have sufficient training and knowledge regarding how the disproportionate burden of trauma and its sequelae fall more heavily on the shoulders

of those with sociodemographic disadvantage and who are living in conditions of protracted poverty. Therefore, it is also our recommendation that more training in this area is warranted.

Preparing children to be ready for school and thereby ameliorating disparities in educational attainment are central foci of early childhood education, and programs such as [Head Start and Early Head Start](#) are specifically designed to level the playing field for children living in poverty and with sociodemographic disadvantage. Our scan suggests that there has been a diminishment of Head Start in rural areas in particular, as well as a lack of available child care facilities for families. Additionally, Early Head Start is not available in all of the counties in WNY, and to further complicate matters, there are waiting lists for local Head Start and Early Head Start programs. Because of this, and because of the chance such programs offer for co-location and coordination of other services important to parenting, we recommend *strengthening of early childhood education in WNY*.



In addition to maintaining, strengthening, and developing universal prevention efforts including home-visiting, infant mental health, parenting supports, and early childhood education, there is a *need for trauma-specific interventions and treatments for the perinatal period* to be introduced in WNY. Several agencies report the use of trauma-specific treatments, including *TF-CBT* (Cohen, Mannarino, & Deblinger, 2006), *EMDR* (Shapiro & Forrest, 2016), *Progressive Counting* (Greenwald & Schmitt, 2010), *Trauma Systems Therapy* (Brown, McCauley, Navalta, & Saxe, 2013), and *DBT* (Linehan, 1987). Yet it is important to note that none of these interventions were specifically designed to address the complexities of trauma related to the childbearing year. We have previously described several trauma-specific interventions that have the goal of addressing the needs of trauma survivors either during pregnancy (*Survivor Moms' Companion*; Sperlich et al., 2011; Seng et al., 2011), during the postpartum period (*Mom Power*; LePlatte et al., 2012; Muzik et al., 2015, *Minding the Baby*; Sadler et al., 2013), or during early childhood (*Parent-Infant Psychotherapy* (Baradon et al., 2010); *Parent-Child Interaction Therapy* (Eyberg, Boggs, & Algina, 1995); *Head Start Trauma Start* (Holmes, Levy, Smith, Pinne, & Neese, 2014). However, as of this writing, we have uncovered only one agency that is using any of these trauma-specific interventions or treatments with our population of interest—an agency which works with children with extreme behaviors is using Parent-Child Interaction Therapy for their parent/child dyads.

We have also previously described *adaptations to existing interventions* that have been undertaken to address traumatic sequelae in the pregnancy and postpartum



period, and recommend their use in WNY. These include *mindfulness yoga* for pregnant women (Muzik, Hamilton, Rosenblum, Waxler, & Hadi, 2012), *mindfulness cognitive behavioral group therapy* for pregnant women (Dunn, Hanieh, Roberts, & Powrie, 2012), *music therapy* for pregnancy (Chang, Chen, & Huang, 2008), and the use of *Narrative Exposure Therapy* for pregnant adolescents (Volpe, Quinn, Resch, Douglas, & Cerulli, 2016).

At this point it is necessary to shift back to the context of poverty and disadvantage. All of the most evidenced-based, trauma- and perinatal-specific interventions in the world will ultimately fall short if women do not access them. We have identified several barriers to access including a sense of discoordination or “fractured” care systems, a lack of early childcare and support for parenting, limitations to accessing substance use treatment, and lack of adequate access to housing and reliable transportation. Initiatives that can help with these practical concerns must be fostered in order to address barriers to accessing services. Yet even when practical concerns are addressed, there is a perception among agency representatives we



interviewed that social stigma is also playing a role in limiting access, particularly for engaging in substance use and mental health treatments. There is also concern that the way clients are treated when accessing services they might qualify for based on income are stigmatizing, as well. This is consistent with the literature on the stigmatizing effects of poverty, particularly since the advent of welfare reform, in that now in order to qualify for services individuals are being “pathologized” (Hansen, Bourgois, & Drucker, 2014), and single mothers of color, in particular, bear undue scrutiny and stigma (Elliot, Powell, & Brenton, 2015). When services are being offered with a big slice of judgment, many may be opting out of everything but the most basic provision of sustenance.

Where can we begin to address social stigma around poverty? Clearly, the answer to such a question will take us outside the bounds of this report. It may be that increasing provider education about stigma will help. Psychoeducation and public health campaigns might be in order. One innovative initiative might hold promise for shifting attitudes toward women who are living with the effects of poverty and are in the process of becoming mothers. Since the 1930s, every new mother in Finland has received a gift from her government during pregnancy, a “baby box”



(Lee, 2013). This gift includes infant clothing and bedding, outer wear, bathing products, diapers, a picture book, and a small mattress designed to provide a safe sleep surface. Other cultures also gift their new mothers similarly (e.g., the boxes are woven baskets called Wahakura for use in the Maori culture in New Zealand; Moon, Hauck, Colson, 2016). In the US,

this idea is starting to take hold, as well—in New Jersey, Ohio, and Alabama (Pao, 2017). Underlying the baby box initiative is a public health campaign to promote safe sleep practices, and the baby box is one among many in terms of initiatives to address Sudden Infant Death Syndrome (SIDS) through the provision of “safe sleep” messaging (Moon, Hauck, Colson, 2016). These messages are also promulgated through community led “baby showers” across the US. Yet, those who are promoting the idea of the “baby box” see an additional role for its use. University of Helsinki professor Panu Pulma acknowledges that the goals of the baby box was to promote safe sleep and encourage breastfeeding and early literacy—but says that “the box” is a symbol. A symbol of equality, and the importance of children. (Lee, 2013). Dr. Kathryn McCans, who chairs the New Jersey Child Fatality and Near Fatality Review Board, which is partnering with a company to provide baby boxes in New Jersey, also acknowledges that while she hopes that the boxes will translate to fewer fatalities, she ultimately doesn’t care whether babies actually sleep in them. “I’m not wedded to the box itself. It’s about the education. It’s about making the boxes available to everyone so that no one feels stigmatized” (Pao, 2017).



INSTEAD OF SHAMING THOSE LIVING WITH POVERTY WHO ARE EXPECTING, WHAT IF WE WELCOMED THEM INTO OUR COMMUNITY IN A SYSTEMATIC WAY, INSTEAD? THE CITY OF BUFFALO HAS A REPUTATION OF BEING A WELCOMING COMMUNITY FOR IMMIGRANTS, ASYLUM SEEKERS, AND REFUGEES. WHAT IF WE ALSO WELCOMED THOSE LIVING IN SCARCITY TO OUR COMMUNITY? WHAT WOULD THAT LOOK LIKE?

In order to create more welcoming, responsive, and thoughtful community through the aforementioned recommendations, we need to address one of the elephants in the room—**funding**. As the scan results indicate and the recommendations require, there is a significant need for money geared specifically toward trauma supports and specifically for mothers and young children. Without additional funding, agencies cannot build capacity to expand upon established programs, hire skilled staff, bring in evidenced-based interventions, or to develop new programs. Financial support is needed to establish universal screening practices, build and maintain a corresponding database and evaluation infrastructure that moves us as a community beyond client satisfaction and on to efficacy of supports and services; building evidence and refining offerings. Small scale funding is needed to conduct another



layer of this very scan to hear from mothers, allowing for client-centered approach to funding and supports. Large scale funding is needed to address the pervasiveness of poverty, creating programs that push toward financial security of women.

Legislative policy directly affects the availability and allocation of funding, and foundations and other funding entities spend time and money on advocacy and lobbying efforts to lean on local, state, and federal officials to

truly serve the women and children they represent. Although there is a tendency for funders to remain a-political, the current climate calls for reconsideration. As major social supports are being threatened, which would jeopardize the health and wellbeing of the most vulnerable among us, funding bodies must weigh in to protect and bolster the existing policies that directly affect the very people they hope to serve with their dollars. There are at least three legislative policies that have direct bearing on the provision of services for mothers and their children in the State of New York, including the Violence Against Women Act, Medicaid Expansion under the Affordable Care Act, and the Department of Human Services Administration's Child Care and Development Fund. Policy briefs for these three major initiatives demonstrating the relevance of each of these policies to services for mothers and babies in Western New York appear in Appendix B of this report.



Immediate Next Steps

We have strong reason to believe that the aforementioned recommendations would prove helpful to WNY mothers and children seeking care for issues of trauma and non-trauma related issues alike. However, one question plagues the efforts currently in place and the recommended efforts—Does our academic understanding of trauma, cycles of abuse and psychiatric vulnerability; social determinants of health, poverty/chronic scarcity, and adverse childhood experiences hold sway with women? The concepts we have detailed at great length in this report are lived-experiences, not “concepts” to the women and children in our communities. Before pressing forward with any of the above recommendations, we suggest a client-centered, qualitative, in-depth study to hear from the very people we are currently serving in WNY. How do they define trauma? What are their most pressing needs? How do they experience the current care landscape? Answers to these questions can only help us to collectively fine-tune our efforts to better serve young families.

Closing Thoughts

Conditions of scarcity (poverty), trauma, and school readiness are arguably inextricably intertwined. To say that there is a temporal order would be a precarious assumption. The truth is that poverty and trauma reverberate throughout a person's lifetime and need to be addressed in tandem to effectively improve school readiness of children living in such circumstances. Although there is a tendency to focus solely on the child's needs, as it is more challenging to blame a child for their circumstances, it is imperative that any movement to improve school readiness and to ameliorate circumstance and consequences of poverty and trauma focus on the mother and baby child. Capitalizing on the perinatal period, meeting mothers and children with supports to help them through and out of circumstances that bind them, creates an opportunity to change the life trajectories of both mom and baby for generations to come.





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Appendix A

Compendium of Quotes



Who are the clients?

“Our folks are usually lower SES. They live crisis to crisis in a sense of the poverty.”

“75% of clients are insured through Medicaid.”

“63.24% of the individuals served were at or below 100% of the Federal Poverty Level, 19.36% were between 101% and 150% of the Federal Poverty Level, and 16.53% were above 151% of the Federal Poverty Level. (A family of four living at Federal Poverty Level makes \$23,850 per year.)”

“For domestic violence program average victim is: single, parenting, white, female, 22–44, living in a household of 3, high school graduate or GED, lives in a rented home, and has a total income of less than or equal to 75% of FPL.”

“Typically white. Many are un/underemployed. Population in the area is young, old, and not much in the middle. Lots of drug abuse. Low income.”

“Drugs are also impacting these families. Seeing this in the larger-family groups, often a single mom who has a lot of kids who start to “run amuck” We have families who are working and have their own insurance and just need help with mental health for their children, families who are intact Racial/ethnic makeup matches county. Low income typically.”

“About 60% of families are on Medicaid, a large proportion are African American. Seeing quite a few Bengalese as well as Arabic families, Caucasian families, and some few Hispanic families.”

“(…) serving individuals between 3 years old (in family context) to seniors”

“Individuals between the ages of 3–21—Family focused.”

“Behavioral Health—18 years of age to geriatrics. Mental health and substance use—12 years of age and up (Very family focused). No specific demographics of mothers available (do not serve young children).”

“2nd chance home, an 8 bed home for 14–21 year women in foster care who are pregnant or parenting (most kids are under the age of 2). Also have SILP—supervised independent living program for young women in foster care—half of which are 17–21 and pregnant or parenting. The other half are 17–21 and not pregnant or parenting”



How do agencies define trauma and have the received trauma-informed training?

“Things that overwhelm a person’s ability to cope such as an event that shakes their sense of safety in the world, often leaving them vulnerable and leads to medical and emotional problems.”

“(...) they don’t have a definition of trauma, but her understanding of trauma is that it’s an event that impacts someone’s life in a negative way.”

“Whenever a person has a life adverse experience that impairs their ability to function.”

“I would say that it’s somebody whose experienced an unhealthy or painful life experience. Often it can be somebody who has been diagnosed with PTSD.”

“Understanding past circumstances and experience that individuals have lived through and how that impacts physically and emotionally.”

“An experience that has happened to you. It’s the person’s perception of the experience. We can’t tell you whether you experienced trauma, the person has to decide that.”

“An experience which causes a person’s thoughts and abilities to diminish or cap their functional capabilities that doesn’t resolve quickly.”

“They recognize that trauma is experienced and interpreted differently for everyone—what may be traumatic to one individual may not be traumatic to another.”

“That’s kind of difficult, it’s a part of every service that we offer. Most people are in a traumatic situation when they come to us, we’re conscious of the experience that they have been through.”

“We define trauma in a wide array of circumstances, but it depends on their personal paradigm where they’re coming from. Not all trauma impacts each person the same way - related to personal level of resilience.”

“Trauma—sexually, physically, emotionally abused, foster care. Trauma can be as simple as they lost their parent—personal trauma. Situational trauma—something big happens in the United States and they react to it.”

“Something that is done to a child that is out of the norm.”



“Agency does not have a definition. The model they work with looks at complex developmental trauma—things kids experience at a young age that involves a variety of traumas and is ongoing. Model includes sexual abuse, physical abuse, violence exposure, witnessing violence, injury or illness, needs not being met, homelessness, and loss of a close family member and war/disaster/displacement. Most of what they deal with is long term exposures.”

“We don’t have an official definition, we would be more along the lines of the experiences that kids have—verbal, emotional, sexual, trauma and trauma base—it varies based on the experiences of children.”

“For us, we look at trauma in both ways. Every child who comes to us has experienced a traumatic event. We have to educate parents on trauma reactions.”

“No agency-wide written definition—anything traumatic that happened in a family, witnessing violence, reunited after long time apart (family reunification—CPS).”

“Yes, they have a contract with UB for trainings. Everyone, including receptionists, are trained when they get hired and they also go through refresher courses. She recognizes that it is a lot more work up front, but it pays off in the long run. Also, all of their partner organizations have to be trained.”

“Staff that are leading are TIC trained and aware. It has really changed the way they train staff. Trained through UB. Tons of webinars and NYS coalition on domestic violence.”

“All staff receive basic TIC training via in person training or webinars. Multiple staff have attended national and state level TIC workshops and webinar. (...) (ITTIC) provides clinical supervision to the CAC therapist. The CAC is currently engaged in the process of assessing and implementing TIC policy/procedures. The CAC Senior Case Coordinator is versed in TIC and assists staff at all levels with implementing TIC services.”

“We are a trauma-informed agency. We’re looking at the perspective of any sort of loss, traumatic loss, any grieving, medical issues, the whole amount of storms down through.”

“Consider themselves a TIC agency—TIC is infused into their work and training. Every clinician is trained in Seeking Safety. Clinicians trained in EMDR, Cognitive Processing Therapy, Progressive Counting

TIC committee—trauma 101 training, infrastructure for TIC, trauma-informed debriefing for staff, team-building self-care for vicarious traumatization, lunch and learns, etc.”



“TIC is one of their 4 tenets of operation—embedded in policies and procedures across all programs.”

“A lot of people understand what TIC is, but do not know how to APPLY.”

“(…) sometimes when trying to “fix” problems or trauma, that in itself can be traumatizing to children because it disrupts their norms. When you try to make things “better” (based on an agency’s own agenda), sometimes it disrupts the homeostasis. Some children have adapted to operate at that heightened hormone level, so when you change the environment, children don’t know how to react. They are cognizant that trauma is in everything they do, but they could be better about this.”

“The agency is very well trauma informed; however, they are not actively treating the trauma. Even in the suicide programs and recovery action program, they are aware that trauma exists, yet there’s a gap in actually discussing trauma with participants. They are working to become even more TIC and incorporating more TIC in programs.”

What trauma-specific services are available for mothers and young children?

“(…) they basically have no specific trauma services for moms/babies. They do groups for women around addiction. Some will incidentally be pregnant.”

How are agencies funded?

Funders mentioned by agencies included:

- Agency Fundraising Events (e.g., Casino night, cocktail parties, etc)
- Allegany County Department of Social Services
- Allegany County United Way
- Catholic Charities annual appeal
- Cattaraugus County Department of Social Services
- Cuba-Rushford School District



- › Department of Health and Human Services (DSS)
- › Department of Housing and Urban Development (HUD)
- › Department of Justice (DOJ)
- › Department of State
- › Department of Veteran's Affairs (VA)
- › Diocesan funding
- › Division of Criminal Justice Services
- › Division of Housing and Community Renewal
- › Dr. Lyle Renodin Foundation
- › Early Childhood Education & Training Program
- › Enough is Enough funding (New York State Senate Bill S5965)
- › Federal Home Loan Bank of New York
- › Fee for Service (via various insurance companies)
- › First Niagara Foundation
- › Friendship School District
- › Genesee Valley School District
- › Governor's Traffic Safety Committee
- › Health Foundation for Western & Central New York
- › John R. Oishei Foundation
- › Letter writing appeal campaigns
- › Lions Club
- › March of Dimes
- › Meaningful Use Incentive IT Grant



- › Medicaid
- › New York State Children's Alliance
- › New York State Office of Children and Family Services (OCFS)
- › New York State Office of Mental Health (OMH)
- › New York State Office of Victim Services
- › Niagara County Department of Mental Health Services
- › Niagara County Department of Social Services
- › NYS Education Department
- › NYS Office of Mental Health
- › OASAS
- › Office of Child and Family Services
- › Office of Community Services
- › Office of Temporary and Disability Assistance
- › Office of Victims Services is largest funding source
- › Other generous contributions from community members and local businesses
- › Other miscellaneous grants and donations
- › Planned Parenthood
- › Private Insurance
- › Private Philanthropy
- › Robert J. and Martha B. Fierle Foundation
- › Rochester Community Foundation
- › Stanley G. Falk tuition revenue
- › The Rehabilitation Center



- › Thrift Store revenue
- › Tower Foundation
- › United Way
- › US Department of the Treasury
- › USDA Rural Development
- › Victims of Crime Act funding (VOCA)

How is assessment, outcomes, and evaluation handled in agencies?

“Evaluation is difficult. They do surveys when they complete the program.”

“Do surveys. Ask participants what their needs (are).”

“Evaluation—group and counseling “rating scales”—satisfaction surveys.”

“Overall goal: improve overall quality of life and wellness; increase self esteem and self worth. Many objectives/outcomes include tracking the services they have coordinated for people (i.e., employment, housing, education, increased visitation with family court, links to medical services, procurement of ID, financial support, graduating Treatment Court, Narcan Training, voter registration, community support).”

“We track birth outcomes, we track referrals made and referrals kept, and then hopefully it’s also the improvement of the level of knowledge about healthy behaviors. We have education sessions for each phase of pregnancy and for birth outcomes. In the beginning, we did hundreds of pre-post surveys, and just found out that people didn’t know anything about pre-pregnancy risks. We can measure if people stopped smoking. We also track depression and mental health.”

“We do pre/post on our programs. Objectives and outcomes is often a negotiation between the therapist and the client about what “done” looks like, and what’s realistically feasible.”



“No set pre post tests are required by the funders, but we are trying to implement that. I see a need for Healthy Steps “plus” and want to look also at more infant mental health resources. We are getting trained in the NBO (Brazelton’s Newborn Behavioral Observation assessment) and also the PDI (Slade’s parent Development Interview). That would enable us to look at reflective functioning at birth and then follow longitudinally. We also hope to look at depression, and mother/baby interaction—which will help with risk assessment. Would like to use three measures to “pump up” home visiting and address risk.”

“Each program offered (...) screens for ACEs and social determinants of health (using a conglomeration of measures to capture). Each program has specific outcomes tracked and evaluated. Has Internal Business Performance Dept—continuous quality improvement loop. Try hard to have clear and concise operationalized outcomes. Create a work flow for each program (logic model). Uses Ages and Stages”

“Outcomes and measurements: IN-HOME has a service plan, so there are goals and they are reviewed every 90 days. FANS (family strengths and needs assessment) is one of the biggest tools we use for measuring the amount of progress. We collect data on Parenting Classes (pre-test/post-test). Family Surveys are done twice a year—are the families getting what they need (this is done with everyone).”

“Just hired consulting group to develop tracking software. Conduct housing surveys—90 days post in-take, annually, and upon discharge. New corporate compliance person on board.”

“Evaluation—those who received TIC training - pre and post tests. After 5 years of training, stopped collecting data. Recently conducted agency survey to determine where the agency is with TIC. Currently tabulating results. Monthly trauma committee—staff and supervisors address general themes and outcomes. Currently looking for objective measures.”

To what extent to agencies partner with other agencies to deliver trauma-related services?

“The local therapists—Spectrum and Wyoming Mental health. We’re very rural. We have not had anything specific to trauma other than we contract with Hillside for foster care. They offer something called TFCBT: Therapeutic Foster Care CBT. We contract with them when we’re stuck and can’t move forward in the healing process.”



“They often refer to Catholic Charities, who have social workers who are trained in trauma, and who take Medicaid and also have a sliding scale. They also refer to private practitioners who they find through the Trauma Coalition’s TIC therapist referral service. Some of the CAC’s families are also referred to Niagara’s P3 Center for teens, moms, and kids, which provides a number of preventative services. In terms of other resources for trauma, Niagara Memorial Medical also has a health home—which provides care coordination for Medicaid eligible children with chronic conditions including complex trauma; there is also an adult health home. There are other parenting programs in the county, but generally these are not trauma-focused.”

“A number of partnerships broadly. None specific to trauma related services but encompassing of trauma related issues. County departments of social services (CPS), mental health; Bureau of Prisons, Federal government.

Satellite offices at Baker Victory, Gateway Longview, and number of Buffalo Public Schools and suburban school districts.”

“They will coordinate with a woman’s OB if she is in addiction treatment around medications. Otherwise, they would refer out to Catholic Charities, Spectrum, etc, if she needed any trauma-related mental health services.”

“The CAC, family and children’s, DV caseworkers, very strong collaboration is part of the program and one of the goals for the grants. She’s also on Justice Dept task forces. Health homes, P3, Mental Health and Behavioral Health in the hospital, try to link the moms and women with the hospital programs, whether it’s a yoga class, a nutrition class, a budgeting class (...).”

“Specific to trauma, I am always looking for counseling services—must take into consideration place, and distance as well as focus when considering who to refer to. Mid Erie has a clinic in our office 3 hours a week for seeing children—but they are also a resource for locating resources for moms. I have referred to Catholic Charities, Child & Family Services, Church Mission of Health, CMH Counseling. More broadly, Harvest House, Community Action, and Catholic Charities: for anyone who is court-involved they have a co-parenting program.”

“Referral to clinics, Spectrum; they assess for postpartum depression.”

“We do not, we would like to implement this. We would like a better relationship with DSS, and trying to work with Justice Center and Advocacy center.”

“We work with a lot of other agencies in the community, we’ll refer people to a lot of different places depending on what their needs are.”



What programs are under development?

- › Developing a self-esteem workshop
- › Developing the reach of a certified peer program for patient advocacy
- › Developing treatment groups for juveniles with Problematic Sexual Behavior
- › Establishing a Health Homes Medicaid program
- › Establishing a mother/daughter support group
- › Establishing an Incredible Years™ hands-on parenting program
- › Establishing parent groups
- › Hiring more clinicians
- › Increasing coordination with housing agencies
- › Increasing liaisons with public health nurses
- › Increasing staff-related trauma supports (like grief debriefing/counseling)
- › Looking into adopting a trauma systems therapy approach
- › Seeking funding to obtain licensure to deliver clinical services in an early head start setting
- › Seeking more support/funding for trauma-related services in general
- › Seeking more training in EMDR, Progressive counting, Solution-Focused Trauma-Informed methods
- › Seeking more training in TIC and TF-CBT
- › Undertaking more fundraising
- › Working on foster parent trauma training



What former programs have been discontinued?

“The one thing we did discontinue which would be good to have was the Respite (child care on site). We did away with this because of funding. This would definitely be a benefit for families that wanted to come for services like trainings or classes, etc.”

“Counseling service. When refunded for collaboration were originally funded in 2009 and had less funding in 2015/2016. 2009–2015 used to include domestic violence specific recovery counseling. Had slots for 8 to 10 individuals and licensed psychologist provided services. Now referred. Would absolutely bring that back. Was very specific and provided by certified psychologist. Referrals that they offer now aren’t as specific. One provider in community is growing more toward domestic, but doesn’t have funding. Funding is targeted more toward sexual assault, not domestic violence. The program allowed for psychologist to address domestic violence as well. General counseling center is not as well trained—isn’t able to do all the training for referral employees—they aren’t as trauma informed.”

“Kinship program—all the kids not raised by parents (maybe 25–30% out here), grandparents etc., didn’t realize that they’re eligible for more services. Used to have a navigator—how to get custody, how to get social security and supports for them, how to legally navigate going to family court, when to get custody, how to work with the guilt of taking custody away from your kid. And just like, aunts and uncles, brothers, sisters, cousins, help them meet the needs of the trauma from the kid, the transient trauma of being raised by a village—the only reason you’re with this person is because they’re above 21 and didn’t say “no.” This really helped a lot. We still do a little, NYS funded it, but this one seriously saved money and helped people out. Grandma or granddad would love 25k, a lawyer, and a volunteer to teach them how to deal with a kid. This was lost because of budget.”

“Prevention education.”

“The CAC therapist is no longer offering Progressive Counting due to inability to obtain consistent supervision.”

What are current challenges agencies face in the provision of services?

“Money isn’t enough to provide for everybody. Beds in shelters are full.”

“More funding, more availability of programs within the county. More professional people within the county—like, people who provide services aren’t moving into the area.”



“Funding is our biggest challenge. We just lost a \$20,000 grant through Catholic Medical Partners that was paying for a part-time volunteer coordinator. We need to supplement this money so we don’t have to let her go. We want to be able to bring on more volunteers to serve ideally ALL the kids that go through the system. More partnerships would also be useful.”

“The bullseye is the funding piece...impacts staffing ratios to clients as well as stress. Agency is really good at getting ahead on the curve. Learning curve for staff around the new E-Record system.”

“I think that the number one would be capacity, especially for mental health and women who are drug-dependent. (...) Sustainability for my program is one of my huge challenges right now.”

“One of the biggest things we’re facing now is lack of time for our mental health providers. We have a waiting list for counseling, up to a month. We really need more treatment providers. We would need more funding but also it’s really tough to find a treatment provider who has the skillset we really need. We feel a very strong obligation to only offer top notch services.”

“We have become an emergency room. The bulk of our work is focused on safety and stabilization—we don’t get to move past safety and stabilization—basic Maslow’s hierarchy of needs.”

“Funding: Our advocates have very limited hours, and they are working their butts off. In a few counties we have a waitlist for family support services. People who start out with family support tend to not need a higher level. We have a workforce who wants more hours, but are limited by funding.”

“(Our) donor base is shrinking. Private unfettered money is shrinking (donations that we can do what we want with). Capacity is increasing in well-funded areas and decreasing in poorly-funded areas. Out this way, we’re able to do less kinship work, less housing work/FEMA, which was big for a while. Partnerships we are working more closely w/ helping agencies to patchwork aid to families—doing more of this. We always need money for trainings. We have the people to do the trainings. Sometimes there are grants. We are going to finally move to electronic case record, which costs 500k and 5k per licensing per user. Greatly increases productivity and allows them to see more people. We got a 100k grant, but like, still need more.”

“More staff—we don’t want a wait list. Teen support group—need funding for staff and curriculum.”

“Building collaborations and resources—bringing agencies together.”



“Partnerships with primary care physicians—there is lack of collaboration. Physicians don’t know what to do with adolescents who are dealing with MH issues. Need training at primary care settings, ED, schools, school counselors.

Co-pays—too much for a family to afford—\$40 for one appointment with commercial insurance.”

“At capacity all the time. Long waiting list. Kids are dumped by primary care physicians—anything beyond minimal psychiatric needs and the kids are handed off and the docs won’t take them back. In other words, struggle to have episodes of care where agency helps to stabilize the kid and then primary takes kid back into care for maintenance.”

“Need help with advocacy in policy and outreach and education for what is truly out there for trauma service. Need to educate people that are making the laws.”

“Every day they are bombarded with new requirements, expectations, and policies that it can be difficult to remain TIC focused.”

“TIC is not uniform across the agency—recognition is the biggest problem.”

“Need more funding for PCIT. Need more evidence-based programs. Need more capacity to serve individuals of other cultures and languages.”

“This first cohort were all given info on Incredible Babies, but none of their families took this up. Trauma affects your relationship with your baby, so we would hope they would (Epic, Catholic Health). Lack of knowledge, lack of time to sit and address this. And then there is stigma, right? That is why having as much here as possible is important. “Everything works better in here.” If we could get funding to do more things in a “medical home.” (Discussed how one particular mom might feel about accepting a referral “out” and the importance of co-locating services.) “No one wants to go to a group for depression.” (Also discussed the importance of social support and how other cultures provide this.) “How do we make it normal to say everybody needs a guide? How do we raise human being?” This should be part of high school curricula...”

“Funding. A long time ago we had parent child center for parents to transition into early head start. Used to have a prenatal program in 96. We had early headstart prenatal services until 2005. Funding got tighter, so had to look at ways to serve largest population. Service got shifted more toward toddlers rather than prenatal. One of the programs that people miss the most.”



What do services providers see as pressing needs of mothers and young children?

“Care is fractured.”

“Data in Allegany County suggests late term introduction to OBGYN services. Not seeing strong prenatal care or getting first trimester care.”

“(…) there’s a noticeable gap between early intervention through DSS. They can work with kids until 3, any other case managers don’t work with kids until the age of 5. She feels there’s a big gap in services available to 3 and 4 year olds.”

“Parenting skills is a consistent need for populations. They are addressing it in program, but because of the trauma history there is a greater need for parenting education.”

“Not sure for stay at home moms how much post support is available.”

“A lot of the kids also need advocacy in schools. Many times they need additional support at school, and parents don’t have a good understanding of rights at school or services that are available to their kids. Need better education of what is available to their children.”

“They struggle with dental care. Everyone’s full or don’t take Medicaid. 6 months out for an apt. and substance abuse. Inpatient is not available for substance abuse, have to travel to buffalo which is a huge issue.”

“(They see) a treatment gap in post-partum care; need more resources and training for clinicians to support moms. (They also see) a treatment gap for the refugee, asylum seeker, and immigrant population (in terms of) supports and treatment. Need more support for agency to build capacity to serve the needs of these groups in culturally responsive/sensitive manner. Need more community building and less medical model.”

“Many women and children are involved in legal system. There’s a big gap in at-risk youth.”

“The state of women focused care is abhorrent. (We) wish to have parenting supports, perinatal supports. There are not near enough postpartum supports; not near enough comprehensive psychiatric treatment available for postpartum women; Need to train clinical staff in perinatal mental health.”



“When I look at the providers, I also want to see them being trauma-informed and providing trauma informed care. Often times they’re not sure how to approach the women, because women are so vulnerable when they’re going through the pre-natal exams. Probation officers could also use trauma-informed training. POs are getting training on disabilities, which is great, but trauma informed training would be great. Online trainings would be useful if they’re encouraged.”

“Another unmet need...we’ve got mental health services here, but a lot of our moms are also survivors, and this is a profoundly triggering event for them. We run into a lot of deficiencies for our communities’ availability to provide trauma-focused therapy. We want moms to be taken care of, and when you look at their role in the recovery process of their children—the caregivers need to be in a strong and healthy place to support their kids. Mom’s ability to cope is reduced by triggering, but the NEED for mom to cope is higher because of the child’s needs. It’s so important to support the non-offending parent. IF we want to support the kids we have to support the caregivers.”

“TIC—there’s huge need for people working in reception. MHA is getting feedback that people feel uncomfortable starting relationship, and if a receptionist treats patients poorly, this can truly break services and help for people or ruin the stage of change the patient is in. Social workers pretty well trained, but front line people also really need the training.”

“Very few health care providers will help women because they are pregnant. Or take weeks to take care of people. Hospitals have turned people away. If you tell them the wait time, the follow up is hard. So they try to get them to follow through with appointments and celebrate through luncheons. MHA tries to bridge this gap by coordinating people as quickly as possible.”

“Paid maternity leave. So many of our moms have to go back to work, many before 6 weeks. Who is going to take care of the infant? How will this affect development? I have to go leave my baby and work a 7–11. If I don’t I will lose my benefits. It’s the most important job in the world, and not only are we not going to pay you to do it, but we are going to punish you if you want to stay home and take care of your kid.”

“(For those struggling with) domestic violence—they need housing, education attainment, work readiness, security, safety, childcare and childcare providers.”

“PREA point person (Prison Rape Elimination Act of 2003) would be awesome for incarcerated folks. Having a dedicated person for the correctional facilities would be helpful.”



“Headstart is decreasing out here. It used to be totally wonderful—good nutrition and good education for young kids. They can’t keep up with the need, and probably are only reaching 25–30% of kids who are eligible. Young kids are getting to school without knowing colors or numbers. Kids really need the wraparound services that Headstart could provide—trauma, nutrition, nursing, primary care provider linkages, and preventative care and assessments.”

“Finding good day care. One mom had her baby in 6 different day cares in the first year—mom had no clue that this matters. “I thought they had to be fed and safe and kept clean, I didn’t understand the importance of relationship.” Day care centers need to be Trauma Informed, as well. Day care providers need to understand the importance of safety and relationships.”

“Buffalo Public Schools used to do more—parenting support and day care—both are needed.”

“Only recently have they gotten the hospital to offer detox services which patients used to have no access to.”

“I feel that addiction and mental health being in separate buckets really harms women who experienced trauma. Trauma may have been before drugs or during the lifestyle. There’s horrible things going on, and I don’t know if they have enough true trauma services to address. Chautauqua has a shortage in psychiatrists and physicians.”

“Substance use disorders are overwhelming—not enough beds.”

“Housing! Better access to drug treatment. But housing, it starts with housing, especially when someone is recently released from jail. More transitional housing that is all female.”

“In Wyoming County there is no shelter. Safe and accessible, affordable housing—not just transitional but also for permanent.”

“Don’t have any homeless shelter for women in children in Chautauqua. Have transitional housing at YWCA, but not emergency housing. It’s only for domestic violence. If someone evicts you—where do you go? They have a men’s shelter reopening, but not for families or women.”

“At risk youth and single mothers—if HUD gets reduced or eliminated it’ll be a huge problem. Safe housing is also a problem.”

“Housing. I think that for a lot of our parents the unmet needs are really fundamental non-medical needs. Everything; not having a car that won’t break down, car seat, diapers, people are struggling. People you would not even expect. Utilities.”



“Transportation is always a barrier. That was the impetus for the satellite locations.”

“Transportation in rural communities—medical/mental health.”

“Transportation—lack of access. Services aren’t available in the county.”

“Issues of transportation in the rural counties.”

“Transportation is a problem. Dunkirk and Fredonia very difficult without a car. Forrestville is even worse.”

“Transportation. The bus is poorly scheduled. Medicaid recipients have a transportation that is operated by the state and subcontracted out...sometimes it works sometimes it doesn’t, and it can be a hassle.”

“A zillion things. Minimal care in so many areas. Minimal shelters, court advocacy. Re-start money for setting up your own apartment. Pet care when moving to shelter (DV), any kid that’s over 4th–5th grade needs a \$100 calculator for school. Educational costs and school supplies—\$50 for groceries is nothing. Anything that increases permanence. Anything that helps them feel permanent—I’m here, I’m going to live here, I’m going to that school, I’m not going to be transient. Developmental security for kids. When your fridge looks different full.”

“The process itself can be better—intake forms and procedures for some programs are stigmatizing and retraumatizing. For example, the Health Homes (HARP) ask individuals in the intake forms to go into grave detail about past traumatic events and provide “proof” of such an event. The process was dissuading potential clients away from applying to the program due to the invasive intake process.”

“In rural areas, intersection of all services and people gets tricky.”

“County has the services, but some of the kids we have the parents have chosen not to engage with DSS—a personality kind of issue and the identity of DSS.”

“Feedback from clients: they feel strong community judgement. They need more awareness in general of what’s out there. It’s a lack of awareness of what’s available and how to access it.”

“Clinicians at the CAC have mentioned that one thing that is lacking is a trauma-focused group for caregivers of children who have been abused. This would be a great addition to individual counseling. In the county at large, there is a sense that not enough energy in general is directed at preventing intergenerational patterns by providing support to parents who struggle with traumatic sequelae, particularly substance use disorders—Niagara County is seeing a lot of babies being born with positive tox screens.”



“Keeping families together. We do not reunite families often enough. Don’t think about the trauma inflicted on a family by removing kids.”

“Need more awareness for people who are taking opiates that if they go on treatment they will not automatically take the children.”

“Babies are being born addicted at a very high rate.”



Appendix B

Policy Briefs

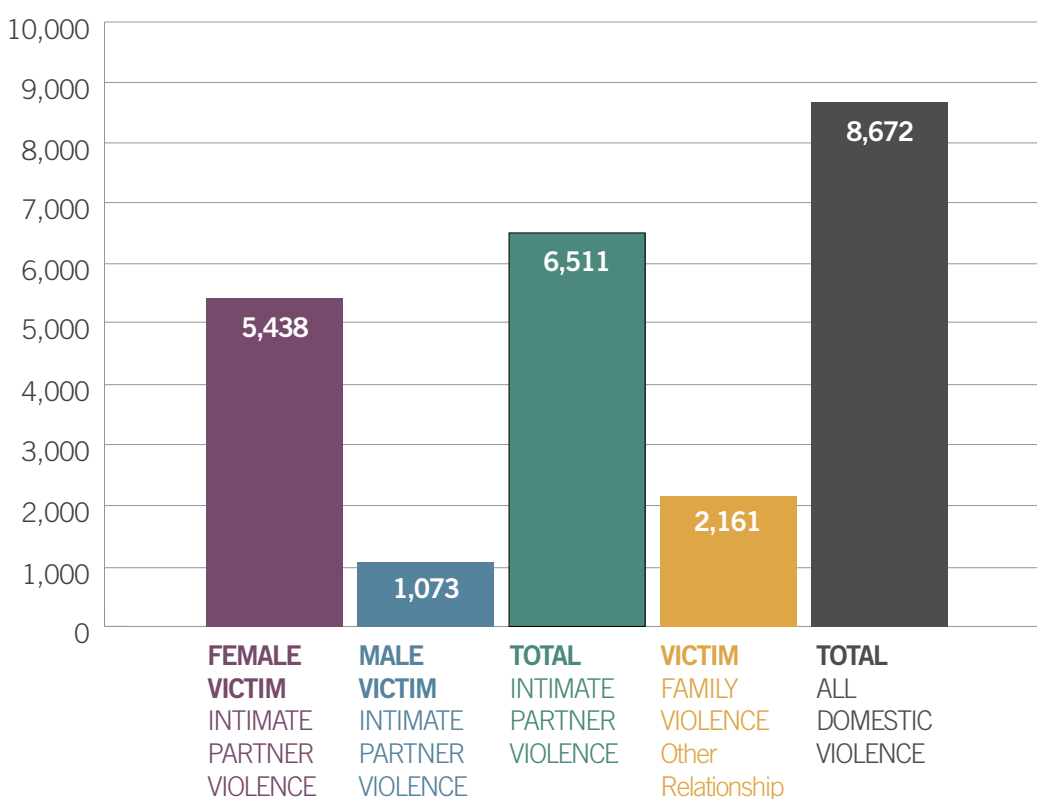


Policy: Violence Against Women Act

The Violence Against Women Act provides funding for services for survivors of domestic violence, sexual assault, dating violence, and stalking. VAWA was originally passed in 1994 with bipartisan support, and has been reauthorized in 2000, 2005, and 2013. VAWA provides resources to state, local, and tribal governments; universities; and non-profits to ensure a coordinated community response to violence **(1)**. Funding from VAWA pays for prevention programming; creating a coordinated community response between public/private sector providers, the judicial system, and law enforcement; investigating domestic violence-related crimes; and programming and protections for special populations.

The reauthorization of VAWA in 2013 included additional protections for survivors of domestic violence, who fall into a number of particularly vulnerable groups, including Native American women, immigrants, LGBT, and college students, and included protections for those living in federally subsidized housing to prevent unfair evictions related to domestic incidents. VAWA is reauthorized through Federal Year 2018.

FIGURE 1. Domestic Violence Victims Reported to Law Enforcement 2016 in 8 WNY Counties (3)





Relevance: A significant number of agencies interviewed for the scan reported that one of the chief issues their clients were facing was domestic violence. Domestic violence is a significant barrier to physical, social, mental, emotional, and financial health and security. An estimated 1 in 3 women will be the victim of intimate partner violence in her lifetime **(2)**.

In 8 WNY, there were 8,672 instances of Domestic Violence reported to law enforcement, perpetrated by intimate partner as well as other relatives, with 5,438 victims being female survivors of intimate partner violence **(Figure 1) (3)**. The true number is higher, as countless women chose not to report to law enforcement.

Domestic violence victimization is associated with a higher risk for depression, suicide, lost productivity at work, PTSD, substance abuse, pregnancy complications, STI infection, chronic pain, and other physical, mental, and reproductive health issues **(2)**.

Annually, 1 in 15 children are exposed to domestic violence—90% of whom directly witness the violence **(3)**. Children who grow up in a home with domestic violence are at a higher risk of becoming victims of child abuse. They experience a number of negative physical, psychological and emotional symptoms, including: decreased concentration, anxiety, depression, behavioral problems, and decreased school performance, as well as longer term effects including increase risk of substance abuse, juvenile delinquency, physical health concerns, and psychological and emotional difficulties in adulthood **(4)**. Perpetration of intimate partner violence, sexual violence, and child abuse and neglect are associated with a lack of economic opportunity and/or unemployment **(5)**.

1. Sacco, Lisa N. "The violence against women act: Overview, legislation, and federal funding." Congressional Research Report (R42499). Washington, DC: The United States Congress, 2015.

2. National Coalition Against Domestic Violence <http://ncadv.org/learn-more/statistics>

3. Domestic Violence Data, New York Division of Criminal Justice Services www.criminaljustice.ny.gov/crimnet/ojsa/domestic-violence-data.html

4. The National Child Traumatic Stress Network: <http://www.nctsn.org/content/children-and-domestic-violence>

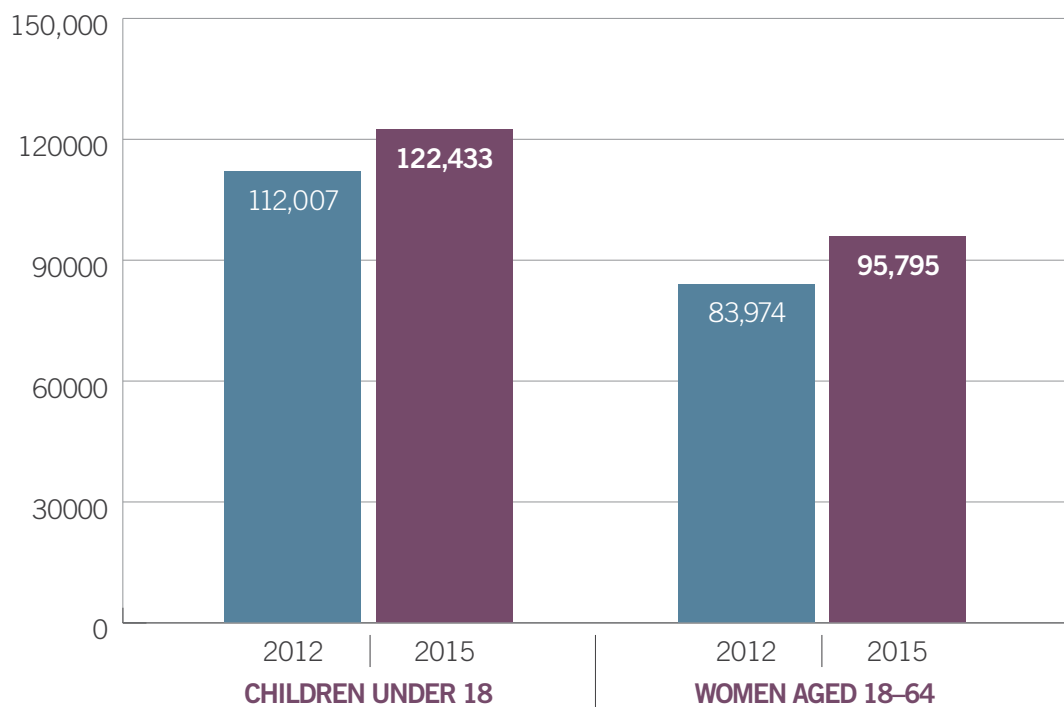
5. Wilkins, N., Tsao, B., Hertz, M., Davis, R., Kleven, J. (2014). Connecting the Dots: An Overview of the Links Among Multiple Forms of Violence. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention Oakland, CA: Prevention Institute.



Policy: Medicaid Expansion under the Affordable Care Act

Medicaid provides health insurance to 69 million people across the United States, including “eligible low-income adults, children, pregnant women, elderly adults and people with disabilities **(1)**.” Under the Affordable Care Act (ACA) of 2014, states were allowed to expand Medicaid to insure people earning up to 133% of the Federal Poverty Level. New York State chose to expand Medicaid. Expansion resulted in increased coverage; increased access to care, utilization of care, and affordability of care; and positive economic benefits for states and providers **(2)**. Families using Medicaid are guaranteed coverage for preventative care, such as early developmental screenings that help ensure early intervention in the critical period of a child’s life. If Medicaid expansion through the ACA is repealed, these critical gains could be reversed, threatening the health and wellbeing of millions of Americans.

FIGURE 2. Number of Individuals Insured through Medicaid, 8 Counties (3)



Relevance: Medicaid is the single largest provider of health insurance to the clients that we wish to serve, vulnerable mothers and young children. In our scan of providers, Medicaid was most frequently listed as the primary health insurance for clients, with many agencies seeing a majority of clients utilizing Medicaid.

There are a significant number of women and children relying on Medicaid for healthcare across 8 WNY **(Figure 2)**. In comparison with 2012, in 2015 more than



10,000 additional children and 12,000 additional women became covered through Medicaid **(3)**. Receiving treatment and services for trauma and the associated physical, mental, psychological, and emotional symptoms is now possible for thousands of women and children in our region who did not have access to affordable care prior to the expansion of Medicaid.

1. [Medicaid.gov](https://www.medicaid.gov)

2. Kaiser Family Foundation Kaiser Family Foundation <http://www.kff.org/medicaid/issue-brief/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review/>

3. American Community Survey 5-Year Estimates, 2008–2012; American Community Survey 5-Year Estimates, 2011–2015. *Author's Calculations*, Retrieved from factfinder.census.gov



Policy: Quality Affordable Childcare

Quality, affordable childcare benefits working parents, young children, employers, and the economy. The Department of Human Services Administration for Families and Children recommends that families should pay no more than 7% of their income towards the cost of childcare **(1)**; however, this is simply not the reality. In Erie County, the annual cost of childcare for an infant is more than \$12,000 **(2)**. In 2014, only 17% of eligible families in New York State actually received childcare subsidies **(3)**.

Childcare assistance promotes equity in early development, school readiness, and supports working parents. Mothers in low-income households who qualify for childcare subsidies are more likely to be employed, to work more hours, and see an increase in earnings **(4)**. The short-term benefits of quality childcare for children include raised IQs, increased achievement in school, and better behavioral skills; the long-term benefits include increased likelihood of high school graduation, and a lowered risk of teen pregnancy or contact with the judicial system **(5)**.

Relevance: The majority of agencies with whom we spoke reported that they were servicing low-income families, single mothers, and/or Medicaid recipients. In 8 WNY, the poverty rates for families with children under the age of 5 are high; the rates for families headed by a single mother are staggering **(Figure 3)**. Ensuring that childcare is affordable directly supports the women and children that are most vulnerable, allowing children to have quality early engagement, and allowing mothers the ability to gain employment and work towards sustainability.

COUNTY	PERCENT OF FAMILIES LIVING IN POVERTY, 8 WNY			
	With Children Under 5		With Children Under 5 and Aged 5–17	
	Married Couple	Single Mother	Married Couple	Single Mother
Allegany	9.1	67.4	22.8	65.7
Cattaraugus	19.0	45.5	19.6	53.2
Chautauqua	14.1	56.1	21.0	74.1
Erie	5.2	53.0	14.5	59.8
Genesee	2.9	55.1	14.8	42.2
Niagara	3.1	55.2	8.4	66.5
Orleans	20.0	43.4	20.2	53.6
Wyoming	0	81.4	11.4	56.3

FIGURE 3. American Community Survey 2011–2015 5-Year Estimates, Poverty Status in the Past 12 Months of Families



1. Child Care and Development Fund (CCDF) Program. 45 CFR Part 98 (2016). <https://www.gpo.gov/fdsys/pkg/FR-2016-09-30/pdf/2016-22986.pdf>
2. Winning Beginning NY Executive Agenda 2017-18. http://www.childcarewestchester.org/pdf/WBNY_Exec_Ask_2017_Final_2.pdf
3. Drury, Tracey. "Child care costs in NY among nation's worst." Buffalo Business First, 25 Feb. 2016. (10) Office of the Assistant Secretary for Planning and Evaluation, Issue Brief. January, 2017. <https://aspe.hhs.gov/system/files/pdf/255471/ChildCareBrief.pdf>
4. Betterley, C., Akhtar, S., Antos, S., & Grasso, G. (2014). *Still Mending the Patchwork*. <https://wnywomensfoundation.org/app/uploads/2017/08/31.-still-mending-the-patchwork.pdf>
5. Taryn W. Morrissey and Mildred E. Warner (2007). *Why Early Care and Education Deserves as Much Attention, or More, than Prekindergarten Alone*. <http://s3.amazonaws.com/mildredwarner.org/attachments/000/000/055/original/106-6ea94867.pdf>