



# Motherhood in love and struggle

Lessons from the Camden Coalition's Camden  
Delivers Program

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# Forward

By Christine Beyer, Commissioner, New Jersey Department of Children and Families

Pregnant and parenting people with substance use disorders (SUDs) who are involved with or at-risk of involvement with any child welfare system face unbelievably difficult challenges that are often exacerbated by a history of trauma. These challenges include addressing their own health and behavioral health issues and working to keep or reunify their families while trying to meet basic needs like stable housing, food, and income. The Camden Coalition, one of the state's statutorily-designated Regional Health Hubs, piloted the program described in this brief working closely with 46 pregnant and parenting mothers with substance use disorders in South Jersey. The Camden Coalition supported these mothers in navigating and managing their own health as well as their involvement with the health, social service, and justice systems. As the brief describes, the biggest "systems" issue for every mother was their involvement with child welfare and the courts. The report describes observations and practices by the Camden Coalition "care team," consisting of a nurse and community health worker with social work and physician support, along with free legal services through the Camden Coalition's Medical-Legal Partnership with Rutgers Law School Camden. The report offers insights and guidance about what we can do — and are doing already — to improve our support for at-risk parents. While the brief is based on the Camden Coalition's work in South Jersey, the insights, lessons, and practical recommendations will be useful to child welfare agencies around the country. Like NJ DCF, many agencies are working to transform their systems to focus on upstream prevention services in order to meet family needs and help them avoid entanglement with child protective services. I am grateful the Camden Coalition captured their work in this brief, and look forward to our continued cooperation with them on these and other collaborative efforts.

# Motherhood in love and struggle

For over 15 years, the Camden Coalition of Healthcare Providers (Camden Coalition) has been working with people who have complex health and social needs (i.e., chronic health issues intensified by other vulnerabilities including the effects of social determinants of health - SDOH). Through programs like the Camden Core Model – our care management work - we have learned from our on-the-ground experience, the necessity of strong networks of social services, healthcare, and behavioral health services (we refer to them “health and well-being ecosystems”) to help people with complex needs meet their health and well-being goals.

**Complex care** addresses the needs of people who experience a combination of medical, behavioral health, and social challenges that result in extreme patterns of healthcare utilization and cost.

Complex care works at the personal and systemic levels, coordinating care for individuals while reshaping ecosystems of services and healthcare. It is person-centered, equitable, cross-sector, team-based, and data-driven.

Substance use disorders are often a qualifying condition for inclusion in complex care programs, including the Camden Coalition’s Core Model interventions. For people with substance use disorders, pregnancy and early parenthood can make an already difficult struggle even more complex. Pregnancy can mean dealing with new or exacerbated chronic health conditions, significant financial strain, increased risk of domestic violence and abuse, and interaction with a host of new medical and social services. And chronic illness, including substance use disorders, can increase the risk of maternal and infant mortality.

We launched Camden Delivers in the fall of 2017 to better understand the experience and needs of pregnant people who use drugs

and are at risk for maternal mortality and other adverse maternal health outcomes. Maternal mortality in the U.S. has more than doubled in the last ten years; NJ ranks 35th in the nation in terms of pregnancy-related deaths. In communities of color these rates are even higher. In Camden, NJ, for every 100,000 women, over 30 women die in childbirth, one of the highest maternal mortality rates in the country. What we quickly learned as we began working with pregnant women and new mothers in Camden was that even more than their substance use or physical health conditions, the major barrier to wellness for participants was their involvement in the child welfare system. Specifically, the threat or reality of losing their children was the overarching issue in their lives. We also saw that systems that could—and should—be working to support vulnerable individuals and families, including the child welfare system, family court

system, social services, and more, often presented additional barriers – despite very good intentions in most cases -- to participants' ability to toward employment, housing, health, well-being, and family reunification.

## Camden Delivers: the Camden Coalition's maternal health intervention

Camden Delivers was launched as a pilot program of the Camden Coalition to better understand the stories behind Camden's maternal mortality statistics. The program focused on people with complex health and social needs, specifically pregnant individuals living with substance use disorder. Our approach is deeply rooted in the principles of trauma-informed care, harm reduction, and the Camden Coalition's COACH model – our approach to working with people with both chronic health issues and SDOH vulnerabilities. The interdisciplinary Camden Delivers staff consisted of a registered nurse and a community health worker (both fluent in English and Spanish) with support from a licensed social worker, housing coordinator, and our Medical-Legal Partnership with Rutgers University Law School.

Camden Delivers identified potential participants through community referrals and a hospital triage system. Participants met the following triage criteria; pregnant Camden city residents with a diagnosis of substance use disorder who had visited the ER or been admitted to the hospital at least once in the previous six months. Staff then conducted outreach and enrolled women into the program in various community settings, including local emergency departments, health clinics, OB practices, homeless shelters, and

**Trauma-informed care:** A philosophical shift from blaming consumers for problematic health or health-seeking behaviors to understanding the roots of these behaviors in early life trauma. A trauma-informed care approach assumes that all participants may have experienced early life trauma; recognizes that trauma shapes health, behavior, self-regard, and interaction with others; and works to avoid re-traumatizing participants.

### COACH stands for:

- **Create** a care plan
- **Observe** the normal routine
- **Assume** a coaching style
- **Connect** tasks with vision and priorities
- **Highlight** progress with data

the labor and delivery floor of local hospitals. Once enrolled, the Camden Delivers care team and participants co-designed individualized care plans to assist participants in meeting their goals. Care plans often included advocacy and support to mothers with open child welfare cases. At minimum, the care team met weekly with patients and provided advocacy and support at child welfare family team meetings, family court, municipal court

(if applicable), and coordinated various referrals to social services and behavioral health agencies.

We enrolled 46 pregnant or post-partum people over the three years of Camden Delivers. Participants' average age at the time of enrollment was 30.8 years, and all of the participants were cisgender women. 28% were Black/African American, 28% were Latinx/Hispanic, 33% were White, and 11% identified as "Other." All participants spoke English or spoke both Spanish and English. More than 80% of participants had a mental health diagnosis, and 75% had dual diagnoses of mental health disorders plus substance use disorder (active or in recovery). Nearly all were living in poverty with unstable or no housing, and few were educated beyond high school. Although we did not formally assess for childhood trauma or post-traumatic stress disorder, we observed in most participants the symptoms and behaviors associated with trauma history. Most commonly, we saw or were told about extreme irritability, hypervigilance, aggression, withdrawal, nightmares, insomnia, mood disorders, and the misuse of medications, drugs, or alcohol to escape unpleasant or intrusive thoughts. Very few participants had a supportive partner involved, sometimes due to incarceration. Some participants had one or two family members, usually their own mother, who were supportive although these relationships were commonly strained and could be unstable.

Despite these life experiences, Camden Delivers participants wanted what most parents want: a future in which they could provide a good life for their children while also achieving personal goals like finishing school, getting a better job, or opening their own businesses. Participants were typically under incredible stress, feeling like they were just surviving. Despite their challenges, participants often kept a great sense of humor and an undaunted ability to stay positive. Our care team learned important information about survival skills — everything from how to stay afloat financially in hard times to how to get photocopies made quickly at social service agencies. Not only did this help the care team learn more about participants' day to day lives, it allowed our care team to help other participants more effectively.

All participants were enrolled in the program while pregnant and all had a diagnosis of substance use disorder. This could include any substance and could include women who were no longer active in their use substance use disorders, pregnancy, and child welfare system involvement are tightly linked: screening positive for drug use at any point during pregnancy, taking prescribed medication for opioid use disorder or any prior history of child welfare involvement are all likely to trigger a child welfare investigation as soon as the baby is

**Harm reduction:** Interventions designed to reduce the negative consequences of harmful behaviors, most popularly associated with substance abuse, are known as harm reduction interventions. These can take many forms, but common examples include needle-exchange programs and opioid replacement therapies.

born. Given this, almost all of our participants were working toward the same goal: keeping or reunifying with their babies and other children in some cases, acquiring safe and stable

*Almost all of our participants were working toward the same goal: keeping or reunifying with their babies and other children in some cases, acquiring safe and stable housing, and working on sustainable recovery from substance use disorder.*

housing, and working on sustainable recovery from substance use disorder. Other common goals included: improving their health and/or mental health, access to transportation, securing reliable child care, getting identification documents, having legal support, and applying for income benefits, food stamps, and Women,

Infants, and Children (WIC) programs. Many of these goals required participants to be able to navigate several complex social service systems.

Five major lessons emerged from our work on Camden Delivers. These lessons encompass our experiences building relationships with women who have lifetimes of reasons not to trust the health and social service systems; strategies for preparing participants for interactions with the child welfare system and family court; and the value of serving as participants' advocates. These lessons, alongside stories from the program, are summarized in this brief.

## Lesson 1: Building authentic healing relationships is essential, takes time, and increases engagement

We found that the history of racism and bias in all systems, including health and social services, coupled with our participants' personal experience with conflict and violence resulted in apprehensiveness toward building trust with new people. The women we worked with were not only striving to meet basic needs like housing and food access, but experiencing something unthinkable to many mothers: potential or actual separation from their babies and other children. Participants clearly and consistently articulated the deep, abiding pain they felt from losing custody of their children. Pregnant participants who were at risk of child welfare involvement because of a positive drug screen were terrified to give birth and have their child immediately taken from them.

This pain and fear became their main motivator for working with us — their primary concern was to keep or reunify with their child(ren). We relied heavily on the principles of trauma-informed care and harm reduction to build relationships that center our participants and that were loving, collaborative, and trusting. These relationships were the foundation for everything we worked to help our participants achieve, and through them, we witnessed powerful stories of motherhood in love and struggle.

Another important component of relationship-building was the care team's ability to provide useful, meaningful resources that could help participants reach their goals. Using existing knowledge of resources and community connections, the care team helped participants build care plans that prioritized the most urgent and foundational goals while also valuing participants' time and effort. The Camden Coalition's knowledge of systemic barriers like the challenges with providing documentation of hardship or identification to access benefits, waiting several hours to apply for or recertify benefits, frustrating features of highly bureaucratic systems, helped the care team predict, prepare for, and often overcome some of the more common system-level hurdles. On the whole, participants who saw value in working with the care team and were willing to build strong relationships with them were often more engaged in the program.

**Authentic healing relationships** is the term we use to describe the secure, genuine, and continuous relationships that our care team members build with patients, and that complex care teams more generally should strive to build with the individuals they serve. The term comes from [this](#) qualitative research paper published by the Camden Coalition.

## Sitting together, building trust – Applying for public benefits

Applying for benefits or gaining access to programs often requires long hours in waiting rooms, leaving participants and care team members with little to do but sit together. This provided an opportunity for participants and care team members to have in-depth conversations, deepening their relationships. They discussed goals, dreams, and plans, and deepened the care team's understanding of participants' histories and motivations.

Another stressor was that waiting areas are rarely designed to accommodate small children. Many participants needed to bring their children with them, which made it difficult for them to complete applications and intake interviews. The care team helped participants fill out forms and paperwork, modeling how to manage the frustration that these forms can often produce. Care team members also prepared participants for long wait times with strategies to keep themselves focused on their goals and their children occupied in hopes of making the experience less stressful.

Sometimes, participants were denied services. The care team would help build participants'

resilience and problem solving by modeling how to respond to the denial. For example, the care team would raise questions about which criteria had not been met and what other services may be available to participants. They also demonstrated when and how to appropriately ask for the help of an employee's supervisor. Walking with participants through systems helped the care team model these behaviors and gave opportunities for participants to practice which improved their ability to navigate systems and get the outcomes that moved them closer to their goals.

## Lesson 2: Staff understanding of the child welfare system improves participants' feelings of self-efficacy

Because the majority of our participants' prioritized reunification with their child or children or maintaining a unified family, the care team found it crucial to better understand and help participants navigate the child welfare system. Variations in child welfare workers' style, level of compassion, and knowledge of the effects of substance use disorders on parents' needs presented challenges. However, the care team used its knowledge of navigating systems and its training in unconditional positive regard to help participants manage difficult situations with child welfare workers, particularly with workers who seemed to be experiencing the effects of burnout. As the care team learned more about how the child welfare system worked, they taught what they learned to participants. Then, the participants could apply those insights to their own interactions with child welfare workers, building participants' sense of self-efficacy and self-advocacy.

## Lesson 3: If approached with a growth mindset, Family Team Meetings can be useful tools for participant growth

Most child welfare systems use "Family Team Meetings" (FTM) to bring together parents/families, child welfare workers and their supervisors, a nurse (if children in the family have been placed in a resource home), and any people that the parents choose to provide them with support; some meetings also include the kinship or foster home resource if a child is placed out of the home or at risk of being placed. The meetings follow a standardized structure and are held at regular intervals, approximately every three months, and – at least in our region in South Jersey – could be called at any point by parent or worker. All FTMs followed the same agenda, designed with a strengths-based approach to guide a conversation about the family's

strengths, needs, and desired outcomes. The meeting culminates in creating a plan to address their needs and goals.

Early on we learned that FTMs could offer valuable opportunities to better understand and influence child welfare cases. When the agenda is followed and the case worker embraces a strength-based, collaborative approach, these meetings can yield powerful results for relationship-building, transparency, and family empowerment. However, we found that the approach taken during the FTMs varied widely based on the child welfare worker's knowledge and style, leading to inconsistent levels of support for participants.

## The power of a positive participant-caseworker relationship

When FTMs are approached in a trauma-informed, transparent, and strengths-based way, participants can benefit from those interactions. This story highlights how the complexity of the parent-caseworker relationship can be navigated through transparency, a strengths-based approach, and support.

One participant had been struggling with a substance use disorder for years, which resulted in her first child being placed with a friend as she worked toward recovery and stability. After several months of progress, she experienced a relapse. She found herself pregnant for a second time while living in an abandoned building. She reconnected with her supports, including the Camden Delivers team, and started progressing toward recovery.

However, the child welfare case with her first child had reached the phase in which a decision about the permanency plan would have to be made. Her child welfare worker called a FTM, and with the permission of the participant, invited the Camden Coalition care team and the friend who had been raising the child since her birth and had expressed a willingness to adopt the child. At the meeting, the case worker and supervisor reviewed and explained where the case was at in the permanency process, highlighted the participant's and family's strengths, and acknowledged the hard work she was putting in.

When it came time to discuss permanency the worker was transparent but also showed a lot of compassion toward the participant. The caseworker validated her feelings and provided options about next steps. In the end, the participant decided she was not ready to parent

due to her circumstances and felt it best that her first child was adopted by the family friend. Understandably, terminating parental rights is an incredibly difficult and painful decision, but her child welfare worker remained supportive and encouraging. She highlighted that the difficult decisions, sacrifices, and the continued hard work she was putting into her recovery were all evidence that she is a good mother: she was making decisions based on what was best for her child even when those choices were incredibly difficult to make. The child welfare worker also encouraged her to keep working toward her goal of parenting the child she was pregnant with. A few months later the participant went to a residential Mommy and Me program where she had her baby. She has since graduated from the program and she and her baby recently moved into their very first apartment.

## Lesson 4: Family court is very stressful, so preparing participants for the experience is crucial

Family court became another important engagement point where our care team was able to have some critical successes both with our participants and with the public systems involved in their lives. In family court, services offered to parents and families can become “orders of the court,” meaning – in some cases -- they must be completed for reunification to occur. For some participants, though, family court produced intense emotions, making it difficult to engage effectively. Complicating many participants’ emotions, in our jurisdiction, family court takes place in the same building as criminal court, invoking memories of their own or their loved ones’ criminal justice system involvement.

Though unintentional, the structure of family court can pit caseworkers against parents, often in ways that seem to undermine the parent-worker relationship. We often heard participants express a sense of betrayal by child welfare workers in court. As one mother said about her caseworker, “She’s two faced: she says one thing to me and then another in court.” Of course, this was not the case with all caseworkers, but again the variability in casework practice was an issue and made it hard, at times, and very unpredictable for our participants.

Participants were typically unprepared for their case when it was discussed in court. This lack of transparency contributed to our participant’s lack of trust of their worker and the child welfare and court systems. Being intentional about scheduling FTMs or phone calls prior to family court dates was an important strategy that some caseworkers used to provide transparency and help participants feel more prepared for court. Because the central care team for Camden Delivers consisted of clinical staff who had minimal knowledge of the legal system, Camden’s Medical-Legal Partnership, a collaboration between the Camden Coalition and Rutgers Law School,

provided invaluable legal support. Furthermore, public defenders from the Office of Parental Rights were willing to explain processes and collaborate with the care team in service of the participants.

Child welfare workers routinely requested information from the participant's substance use treatment providers to present in court. The information requested is often limited to program attendance and drug screen results, and

*Being intentional about scheduling FTMs or phone calls prior to family court dates was an important strategy.*

holds significant weight in determining the outcomes of family court cases. Because we thought there were other measures that could present a more comprehensive picture of how

participants were progressing toward their goals, the Camden Coalition asked program providers to provide letters that included a wider range of data points. We found that providing additional context and guidance about how the results could be interpreted by non-medical professionals like child welfare staff, lawyers, and judges was important to avoiding misunderstandings that could impact the trajectory of child welfare cases.

## The importance of preparing participants for family court and managing trauma response in a stressful family court environment

When parents and children arrive at the entrance of the family court building they are met several police officers. Upon entering everyone is made to remove all personal belongings including belts and pass through metal detectors. Parents and children will encounter several more police officers as they wait to be called and again when they enter the courtroom itself. Anxious parents and children sit in plastic chairs lining the hallway waiting for their case to be called. It is often noisy and crowded, and families may wait several hours for their case to be heard. Children sit, legs dangling and swinging anxiously, or they are carried up and down the hallways by their parents or guardian in an effort to occupy their attention. At least in the court where we accompanied our participants, there was no family accessible bathroom and no changing table in the gendered bathrooms. Child welfare workers and parental rights lawyers hustle and weave through the crowded hallways calling their clients into small rooms or pulling them aside in the hallway to briefly discuss what will happen in court that day. Once in the courtroom before the judge, parents sit on one side of the courtroom and the child welfare caseworker and the agency's attorney sit on the other.

Participants often struggled in family court. One participant experienced a panic attack and on another occasion became verbally aggressive with her child welfare worker and her lawyer. Other times, she became apprehensive about attending court at all. The care team helped her develop strategies that could improve her family court experiences and outcomes. Strategies that worked were planning Family Team Meetings a week or two before court to learn what would be discussed and connecting our participant's vision of reunification with her actions of showing up for court and participating in the process.

Before court dates, the care team facilitated conversations with this participant focused on connecting her goal of reunification to the task of having a productive day in court. We also encouraged her to be proactive in identifying moments that were producing strong emotions and using coping strategies like deep breathing, asking for breaks, and taking short walks to help her stay focused on her goals. As the care team could not enter the family courtroom, they involved her parental rights lawyer, who would be with her in court, in these preparation sessions. Family court never became pleasant or easy for her, but these strategies improved her experiences and gave her more confidence in navigating the other challenges she was experiencing. She once proudly reported to our care team a story of when she was on the phone with her caseworker and felt herself getting upset but decided instead of "cursing him out" like she had in the past to instead tell him she was feeling upset and needed to call him back later.

## Lesson 5: A negative participant-caseworker relationship can de-motivate participants

The ability to develop a productive relationship with the child welfare caseworker seemed like a consistent stress-inducing obstacle for our participants. In most cases, parents are not able to request to be assigned a new caseworker. Learning to navigate varied workers' approaches became another key element of improving outcomes. Some women who described having a poor relationship with their child welfare worker were aggressive with and avoidant of their worker — both of which are common trauma responses. Participants also sometimes acted aggressively in or tried to avoid other requirements, including the court-ordered activities like therapy or parenting classes. Some participants would not attend court-ordered therapy sessions and others would attend the sessions but would tell the care team that they did not participate in the therapy.

Participants were often overwhelmed by the schedule they were expected to keep of mandated services. Parents who are working toward reunification with their children are often required to engage in several activities including intensive substance use treatment programming, random drug screens, substance use and mental health evaluations, therapy, parenting classes, anger management, visits with their children, family court hearings, and meetings with their child welfare workers. This very busy schedule often precluded participants from securing a job. Additionally, parents of children who are living with another family can be charged for child support until either reunification or adoption occurs, exacerbating their financial hardship.

Adding to frustrations, a combination of case worker knowledge and approach toward parents and systemic barriers seemed to make it prohibitively difficult for parents to access any meaningful resources to support them with basic needs like housing. Many workers seemed like they themselves were struggling with compassion fatigue which can manifest as apathy, irritable demeanor, being judgmental, and binary thinking. The cumulative effect of these kinds of experiences could bring even our most motivated participants to become less hopeful, feeling that their efforts were in vain and deepening rifts between case workers and parents. One participant, who was four months postpartum, described her experience this way: "I feel like everyone is always watching me and I have to be perfect or they won't give me my baby back. It's a lot of pressure. I have so many parts of my life I'm trying to work on and it's just... a lot."



In some cases, the care team had opportunities to model to child welfare workers how we talk with participants about their recovery goals with transparency and with the spirit of collaboration versus focusing the discussion on mandated treatment and substance use cessation which seemed to be the dominant approach of most caseworkers. Few case workers or supervisors were knowledgeable about substance use disorders, treatment, and recovery even though problematic substance use is a very common reason for child removal. In one instance, a child welfare worker called the care team to ask about a participant's recent positive urine screen because she was concerned and wanted to make sure there she was not misinterpreting the information. This was a great opportunity for the care team to explain the non-linear nature of behavior change and the reality that relapse is a typical part of recovery and does not mean the participant is not committed to sobriety or can never gain sobriety. We also shared how we were able to have these difficult discussions with participants with transparency, compassion and support rather than in a punitive context.

We found health professionals could be very helpful to bolstering support for our participants with both the child welfare system and the court. We regularly encouraged participants to include their health and other treatment providers in conversations with their caseworkers and to ask them for letters of support for court. The child welfare system seems particularly responsive to the recommendations of medical professionals who can provide valuable context with a letter accompanying any drug screens requested by the child welfare system. We found these strategies were very successful in empowering participants to self-advocate, as well as in educating child welfare workers.

## Empowerment through bringing together full care teams and advocating for mothers' growth and potential

Camden Delivers was designed to help empower participants to navigate systems in high stakes situations, but sometimes it was helpful for our care team to step in and provide additional advocacy. In one such example we were working with a participant whose baby was placed into a resource home after birth. The participant was very motivated, proactive and engaged in her treatment and recovery. She was evaluated and recommended to go to a Mommy and Me program which is a long-term residential recovery program designed for mothers and their children to be reunified during treatment. All she needed was a referral from her child welfare worker to complete the Mommy & Me program application.

Everything seemed on track until we learned that her case worker did not plan to provide that referral and in fact was planning to recommend at the upcoming family court date to expedite the case to termination of parental rights. We quickly encouraged the participant to schedule an FTM, and helped facilitate the inclusion of her treatment providers who were assisting her with the application and intake process for the Mommy and Me program. After nearly two hours of tense discussion, education, and advocating, the worker and her supervisor consulted and agreed to change their recommendation to the court endorsing the recommendation of two clinical addiction specialists that she attend a Mommy and Me program. The participant left the meeting feeling grateful for the advocacy. "If only I had had your support with my last child welfare case," she said, "many things would have gone differently." Her parental rights had been terminated in that case.

After over 10 successful months in the Mommy and Me program, this participant graduated from the program and reunified with her baby in February 2020. Today, both mother and baby are doing well and we are continuing to support this participant in her goal of getting their own apartment. It was our experience that identifying and quickly responding to high stakes moments like these could, in some cases, significantly alter reunification outcomes. While the Camden Delivers team played an important role in bringing this participants' various team members together, we could not do it alone and often relied on community partners to enhance the teaching and advocacy for women living with substance use disorder.

## Final thoughts and recommendations

Many Camden Delivers participants were able to reach their goals for themselves and their families. However, the program had to quickly evolve from its initial intent to support health and well-being for pregnant and post-partum people in Camden to working alongside them to navigate child welfare, family court, social services, and other systems. The participants, who were working hard to reunify with their children or avoid having their children taken from them, had trouble meeting their own basic needs. The systems that were put in place to support them were, in many cases, just adding to the complexity and precarity of their lives.

To improve outcomes for people like our Camden Delivers participants, changes need to be made throughout these systems so that authentic healing relationships can form and lasting behavior change can happen. Recommendations for how to better support pregnant and post-

partum people who also have complex health and social needs and are involved with health systems, child welfare, the courts and other social services include:

- Creating collaborative care plans that bring together all of the providers across all systems that engage women and children (i.e., creating a “team” focused on a positive goal is essential);
- Educating health, child welfare, court and social services workers in the biology and psychology of substance use disorders, harm reduction practices, and local resources available to people with addiction;
- Implementing trauma-informed approaches in all social service and healthcare settings, especially child welfare systems; and
- Prioritizing activities required for reunification to allow parents to obtain housing, work for income, and care for their child and/or their pregnancy.
- We met so many people working for health, child welfare and other social services systems who care deeply about the participants in our care. The practices of the systems often got in their way of providing help. A focused and cross-system effort to approach this issue differently could have markedly different and more positive results for families and their children.



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## About the Camden Coalition

We are a multidisciplinary nonprofit working to improve care for people with complex health and social needs in Camden, NJ, and across the country. The Camden Coalition works to advance the field of **complex care** by implementing person-centered programs and piloting new models that address chronic illness and social barriers to health and wellbeing. Supported by a robust data infrastructure, cross-sector convening, and shared learning, our community-based programs deliver better care to the most vulnerable individuals **in Camden** and **regionally**.

The **National Center for Complex Health and Social Needs** (National Center), an initiative of the Camden Coalition, connects complex care practitioners with each other and supports the field with tools and resources that move complex care forward. The National Center's founding sponsors are the Atlantic Philanthropies, the Robert Wood Johnson Foundation, and AARP.