FINAL EVALUATION
OF THE
JERSEY CITY MEDICAL CENTER'S
HUDSON CRADLE PROJECT

by

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SUMMARY

Hudson Cradle operates a transitional residence — in effect, a group home — for boarder babies and other medically fragile infants and toddlers who are referred by, and under the supervision of, New Jersey’s Division of Youth and Family Services (DYFS), the State’s child protection agency. The Project, which occupies a converted brownstone and is affiliated with the Jersey City Medical Center (JCMC), actually began operations in late 1991 when it removed its first medically cleared child from one of the hospital’s wards.

Hudson Cradle’s main goals are to avoid the prolonged, costly and unnecessary boarding of infants and toddlers at Jersey City Medical Center and other area hospitals; to care for the daily needs of these very young children, while focusing especially on their health and developmental issues; and to work with their parents and other caregivers around family reunification or placement. Hudson Cradle’s staff include an on-site Project coordinator, a registered nurse, a social worker, licensed practical nurses, and infant caregivers who provide 24-hour, 7-day-a-week care while children stay at the facility. Besides residential services, the Project primarily offers case management, family support, medical care, and early developmental intervention.

From late 1991 through July 1997, DYFS placed 169 children in Hudson Cradle. Four-fifths of their birth mothers had at least one prior allegation of child abuse or neglect registered against them; and over two-fifths — or half those with older children — had previously had another child removed from their care. Almost two in three had received no prenatal medical attention for the child referred to Hudson Cradle; and five in six had abused drugs or alcohol while pregnant — mostly cocaine, and often in combination with other controlled substances or alcohol. A sixth of the Project’s children had been born HIV-positive; and an eighth had been exposed by their pregnant mother to another sexually transmitted disease. Two in five were born prematurely; and half had a low birth weight — both highly significant predictors of a child’s future health and developmental risk. Close to two in five exhibited symptoms of drug withdrawal — like extreme irritability, jitteriness, and tremors; half experienced other neonatal complications; and a fifth were also noted to have a congenital abnormality. As a result of their medical and social circumstances, the typical infant referred to Hudson Cradle had experienced a prolonged neonatal hospitalization — their median inpatient stay lasted 31 days, about half of which was medically unnecessary.

Their average stay in Hudson Cradle lasted another two months. Once a child was in the facility, family members tended to visit more and to have more contact with their caseworkers than during the immediately preceding period. Service provision rates also rose, but more for the children than for their birth parents. In managing the cases at Hudson Cradle, there developed a general division of labor in which DYFS workers tended to see birth parents at their homes or elsewhere in the field and to arrange for most of the services that the parents received. Hudson Cradle workers,
on the other hand, usually met a family member when he or she came to visit the child on-site and limited their interaction to counseling and various referrals — especially around substance abuse and parenting skills — while focusing more of their concern on the child's needs.

Only a fourth of the children left Hudson Cradle to go live with a birth parent or other family member; almost all the rest went into a foster home. After a child was discharged from Hudson Cradle, overall rates of both child visitation and contact between caseworkers and the birth family decreased. Nevertheless, as of last count, by July-August 1997, almost half the children discharged from Hudson Cradle had been reunited with a family member — one in five, with a parent; and one in four, with another relative — while another fourth were in an adoptive or pre-adoptive home. The rest, just over a quarter, were still living in a foster home.

Boarder babies who stayed at Hudson Cradle during its first two and a half years experienced DYFS case histories that were similar, in most respects, to those of a comparable group of children who had not stayed at the facility. The few significant differences found between these two groups in contact and visitation rates, service provision, and outcomes, generally occurred during the period right after the children had been released from the hospital, while some were residing at Hudson Cradle and others were not. Overwhelmingly, these differences then seemed to narrow — if not disappear altogether — with the passage of time, leading us to conclude that the Project demonstrated no lasting effect on the children's DYFS cases.

Over the last six years, Hudson Cradle has provided excellent residential care to 169 hospital boarder babies and other infants, a number of whom were medically quite fragile. Virtually all were developmentally screened and received early intervention services, along with medical treatment and daily care, including food, clothing and shelter. A viable staffing pattern — encompassing the Project's medical, developmental, social service and caregiving functions — evolved. Highly qualified professionals, who knew their field and the community, were recruited, trained and placed in position; and the Project's line staff, most notably the infant caregivers, were committed, resourceful and effective. Project administrators were open to constructive criticism and suggestions; and significant progress was made regarding the Project's outreach efforts, in-service training, and recordkeeping. Everyone involved is demonstrably proud of their facility, and its program still holds out great promise for Hudson County.

These accomplishments were not insignificant, given the various logistical and procedural obstacles with which the Project had to contend, early on. Nevertheless, there were major drawbacks, including a persistent problem with keeping all Hudson Cradle's beds occupied. Also troubling was the staff's inability to meaningfully engage many of the parents and other relatives of infants staying at the facility, as well as DYFS's inability to integrate the positive things that were sometimes happening at
Hudson Cradle — especially when there was increased family involvement — into its case plan for the children after they were discharged into foster care.

The main issue that confounded the Project from the outset was being caught in the middle, between the conflicting agendas of its two sponsors. The ongoing contention between DYFS and JCMC was not a simple matter of personalities but rather a reflection of quite disparate concepts about service delivery which the two organizations had developed, over many years, in response both to their own target population as well as to the legal and administrative mandates under which each must operate. Basically, DYFS, a social services agency, viewed the Project as a child protection vehicle; while JCMC adopted a hospital-based paradigm. These two models assume different constraints, promote distinct administrative styles, and involve dissimilar expectations.

In the evaluator’s view, these differences resulted in a series of concerns — summarized below — which were never quite resolved:

JCMC and Project staff tended to treat the infant as their principal client; and the infant’s condition often required that medical and developmental case management be their principal concern. From DYFS’s perspective, the child’s birth parents had to be considered the Project’s clients just as much as — if not, at times, even more than — the children; but their needs were legally defined for DYFS as centering on issues related to placement and permanency.

DYFS caseworkers tended to deal with parents around their need to establish a baby’s paternity, enroll in a substance abuse treatment program, and secure adequate housing — typical issues for most DYFS cases, that bear directly on the possibility of reunification — rather than explaining the Project’s unique services and goals. So, birth parents often may have felt that their child’s placement in Hudson Cradle was simply how the "system" responded to their own substance abuse or homelessness and had no idea how they and their child might otherwise benefit.

Project staff had a modest amount of contact with most family members while their child was on-site and hardly any, once the child had been discharged. Instead they followed a service strategy common to hospital settings: children receive services on-site, either when visiting a clinic or after being admitted as an inpatient. Since decisions about the timing of each child’s discharge and his or her subsequent placement were solely within DYFS’s purview, anyway, Project staff usually were unable to carry through on any plans they might have had to strengthen family bonds while a child was with them and to promote reunification. On the other hand, any "credit" for a family reunification which took place after discharge accrued to DYFS.
Because DYFS determined that a child must first have a case with the agency before becoming eligible for Project services, JCMC could not transfer a child to the Project's facility until a decision regarding the placement of that child had been made by DYFS and/or the Family Court. DYFS faced severe legal and case-practice constraints which governed when it could assume responsibility for a child. Thus, the agency was typically unable to expedite referral to the Project of infants who were medically cleared for discharge, if their parents — or another family member whom the parents had designated — were still being considered as potential caregivers.

Other complications arose from so many of the children being classified initially as medically fragile and thereby requiring that they be discharged to a specially-trained foster home. Since there often were not enough of these providers available locally, a substantial minority of the children ended up out of the area. This had the effect of distancing a child — physically and emotionally — from its birth parents. In such circumstances, both parent-child and parent-caseworker relationships suffered; and this was reflected in lower rates of service provision as well as child visitation after discharge.

While it is our conclusion that Hudson Cradle never quite fulfilled its great promise — in large part, because of the organizational relationships and service strategies put in place six years ago — it should be borne in mind that the Project has had an impact greater than that accomplished with the families it directly served. Clearly, it is the hope of all involved that Hudson’s Cradle’s work with the 169 cases described in this report will ultimately result in decreased child welfare costs when family members are reunited; lower social welfare expenditures when parents become more self-supporting; fewer medical care costs after chronic and/or congenital health conditions are resolved; and reduced special education expenditures once children’s developmental delays are evaluated and early intervention services provided.

In the near term, however, Hudson Cradle’s consistent emphasis on identifying potential boarder babies early on and expediting their release from the hospital to a family member or into foster care has helped influence state, local and hospital policies and procedures — speeding up the decision-making process around, and the service delivery system’s response to, each medically-cleared infant being held in a hospital bed awaiting discharge. The cumulative effect of these changes, over the long run, may end up being of greater consequence to the area’s boarder babies than the direct provision of Project services to targeted clients.
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A. BACKGROUND

New Jersey's Division of Youth and Family Services (DYFS) was awarded a multi-year grant by the U.S. Department of Health and Human Services, pursuant to the Abandoned Infants Assistance Act, for a proposal entitled "Transitional Residence and Multi-Purpose Resource Center for Boarder Babies and Their Families." DYFS subsequently subcontracted with the Jersey City Medical Center (JCMC) to operate the newly funded Project. The Medical Center, which had already taken the initiative by enlisting various community representatives in establishing a separate non-profit entity, Hudson Cradle, to address the boarder baby issue locally, then asked this body to share responsibility for Project oversight as well as to help raise additional funds for the effort. In time, the Project itself took on this group's name; and it became known simply as "Hudson Cradle."

One of the conditions attached to the original federal grant was that an outside evaluation of the Project be conducted. The report that follows spells out the methodology, findings, and conclusions resulting from this evaluation.

1. The Boarder Baby Crisis

By the late 1980s and early 1990s, family disintegration which was caused, most notably, by homelessness and substance abuse — especially the use of "crack" cocaine by mothers and pregnant women — had resulted in a dramatic nationwide increase in the incidence of boarder babies. These are infants who remain in the hospital after birth or treatment, even though they have been medically cleared for discharge, because they have been abandoned there by their mothers, because of concerns about their parents' ability to provide adequately for their welfare, or because an appropriate relative or foster family with which the child could be placed has not yet been located. In addition, hospitals sometimes are used as holding areas during child abuse and neglect investigations, or when an agency like DYFS is seeking to obtain a voluntary agreement from the parents for foster care placement or, in the absence of such an agreement, a court order accomplishing the same purpose.

DYFS policy dictated that the agency place a medically cleared child who was on "social hold" — i.e., one whose time and means of hospital discharge was under DYFS's supervision — within three days; but, by early 1990, alternative caretakers and foster care resources had become overburdened to the point where they no longer could meet the demand. To compound matters further, a significant proportion of boarder babies have medical and developmental problems stemming from maternal alcohol or other substance abuse, a history of poor prenatal care and nutrition, and — all too often — infection by sexually transmitted diseases, hepatitis or HIV, any or all of which can necessitate that such an infant (generally classified by DYFS as "medically fragile") be placed in a specialized foster home whose members have been trained to provide care for this type of child. In fact, a study conducted by DYFS in 1989 revealed that, at the time, 44 of Hudson County's 58 boarder babies had such special needs, that none of them could be placed within the 3-day limit, and that they comprised about a third of all special-needs children statewide who were awaiting placement beyond three days.
Not only does a hospital provide an unstable environment for a growing infant, as well as the ever-present risk of exposure to contagious disease; but it also happens to be a very expensive form of care, typically costing as much in just a few days as, for example, a foster family’s stipend does per month. Moreover, while nurses and volunteers may do their best to nurture a boarder baby, they have neither the time nor the constancy of focus to equal the love and care that parents or other guardians can bestow on a child in their own home. As a consequence, boarder babies often miss the opportunity to share in the critical attachment experience that a stable relationship with one caretaker can produce. Arguably, all these factors might have long-term negative influences on a boarder baby’s future development.

Despite some press articles to the contrary, a survey by the New Jersey Hospital Association of its member institutions found that "when comparing 1991 data with 1993 data...most of the hospitals reported the same number or a higher number of boarders [and the] greatest incidence of boarders was reported by inner-city and urban hospitals." The study also revealed, in both 1991 and 1993, not only that Hudson County was among the State’s top three counties in terms of the number of boarder babies registered during the first calendar quarter in each year but also that Jersey City Medical Center housed over three-fourths of the County’s total each time. The study showed that, statewide, almost three in five boarder babies stayed no longer than a week extra in the hospital, while close to a fifth remained for a month or longer. The hospital social workers who were surveyed had attributed most of these longer stays to three causes:

- DYFS’s backlog of children already waiting for a foster care or adoption placement (32%);
- children held by DYFS pending the outcome of a child abuse/neglect investigation (25%) or the negotiations around securing a placement agreement; and
- drug screening to determine if the mother had been using a controlled substance prior to the time of delivery (11%).

2. A Brief Chronology of the Project’s Start-up

When Hudson Cradle was incorporated in mid-1990, JMC’s boarder baby census had reached a daily average of 23 infants; and the organization’s principal objective was to open a transitional housing facility, providing residential care seven days a week, 24 hours a day, in a “home-like” setting, for boarder babies staying at Hudson County’s hospitals. Such a facility was expected to permit the timely discharge of medically cleared children from these institutions and to provide a full range of medical, psychological and social services to the infants and to their birth and/or foster parents. Several possible sites for the facility were investigated in late 1990; and in February 1991, the Hudson Cradle board selected a building close to — and owned by — Greenville Hospital, in Jersey City. Subsequently, over $230,000 in two community development block grants was secured for the renovation of this site.

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DYFS had participated in the planning for Hudson Cradle; and, when the agency submitted its proposal to the Federal Government in August 1990, it envisioned a facility in which ten infants could be housed, receiving food, shelter, clothing, and medical care by trained caregivers and other staff, as well as appropriate developmental intervention, including infant stimulation. The parents, in turn, would be encouraged to visit their children on-site and to receive counseling, support, and parent training, as well as medical and other services. Further, the Project would mount community health education programs around teenage pregnancy, substance abuse and prenatal care; and it would assist DYFS in recruiting and training additional Special Home Service Providers — i.e., "SHSP" foster families, to care for medically fragile infants and other children with special needs.

The federal grant award for the Project was effective April 1, 1991; however, DYFS then had to initiate a necessary but time-consuming process of soliciting bids from appropriate organizations to implement the plan it had delineated and to provide for the Project's day-to-day administration. A lengthy series of steps — including identifying potential subcontractors, developing an RFP, and evaluating the five bids that were received — culminated in July 1991, with the selection of Jersey City Medical Center, itself, to run the Project. The Project accepted its first case for service the following month, in August, although it still had no facility in which to house the child; and contract negotiations between the JCMC and DYFS continued for two months afterwards. The Project's official operational start took place in November 1991, some seven months after the grant had been awarded.

At that time, one major hurdle remained to be cleared: the building in which the program was to be housed had to be renovated. Approval of the proposed changes to the site required that a use variance be granted by Jersey City's Zoning Board of Adjustment; and this, in turn, hinged on Hudson Cradle's being able to secure an easement from a physician who owned an adjacent building. At its November 14, 1991, meeting, the Board of Adjustment granted the necessary variance for the site; however, the proposed construction schedule anticipated completion about a year later, around November 1992. DYFS informed the Medical Center that, since conditions of the federal grant would not permit further delays, provision of direct services to infants would have to begin in the near future, utilizing temporary arrangements. As an expedient, the Medical Center set aside a room in the hospital where as many as five Project children immediately could be transferred and cared for; and then it quickly located a small but suitable residential building, at some distance from the intended site, which could be readily converted into an interim facility.

Practically coincident with the Project's start-up, the Medical Center's boarder baby census began retreating dramatically from its historically high level; and a fairly large number of infants who just recently had been on social hold were discharged from the hospital, either into foster care or released to a birth parent or other relative. For the next three and a half years, the number of medically-cleared infants at the Medical Center generally remained well below its former level, often locked in a fairly tight range around ten children. These data are shown graphically in Chart 1, in which the bars represent the number of children under four years of age who remained inpatients after being medically cleared during each month, from October 1991 through March 1995; and the line represents the average number of days that these particular children remained on-site after being cleared that month. The chart tells us that the average unnecessary stay of infants and toddlers at JCMC dropped substantially, with the
CHART 1. MEDICALLY CLEAR CHILDREN AND MEAN HOSPITAL STAY AFTER BEING CLEARED

Jersey City Medical Center
(inpatients, age 0–3 yrs, 10/91 – 4/95)

[Graph showing data on chart 1]

CHART 2. HUDSON CRADLE INTAKES THROUGH 7/31/97
Children Who Stayed at Hudson Cradle
(8/91 – 7/97)

[Graph showing data on chart 2]
advent of Hudson Cradle, even as the number of medically-cleared children staying on-site rose erratically. The average medically-cleared stay of children under four years of age at JCMC fell from 30.2 days during the initial six-month period of October 1991 through March 1992 to 18.4 days in the twelve months that followed, 16.6 days the year after that, and 17.3 days during the last 12-month period (through March 1995).²

There were two conceptual drawbacks to the Medical Center’s plan — adopted at DYFS’s urging — of setting aside a ward in the hospital for several Project children, while a small residential building was being converted into an interim facility. First, the Project was being rushed into operation only partially staffed up; and, as things turned out, a new program coordinator did not come on board for several more months. (JCMC directly administered the Project in the meantime.) Second, the converted interim facility was able to accommodate just five children; so, once it was put into use, the hospital ward still had to be utilized for any overflow whenever more than five boarder babies were enrolled in the program at a time. During such periods, Project staff had to be deployed across two sites.

The Project accepted two more infants for services through December 1991, and all three cases were cared for at the hospital itself since the interim facility was not yet ready to receive referrals. In January 1992, a program coordinator was hired; and the Project was almost ready to begin full-scale operations. The new coordinator was a highly qualified occupational therapist, with a Ph.D. and recent experience in another program serving HIV-positive and drug-exposed children. However, he was not the nurse practitioner called for by the original plan — a fact which would bear on his success in the very near future.

Only two children were under care in February, both staying at the hospital. During the month, DYFS’s Hudson County manager issued guidelines, for staff of the County’s three district offices, describing the new Project and its services and explaining how to access them. The first baby actually to be moved into a crib at the interim transitional residence arrived in March 1992 — about a year after the Project’s federal grant award. Informational sessions were scheduled at all three local DYFS offices to explain the Project and to solicit referrals. While DYFS staff generally voiced appreciation for the Project’s concept, they raised several concerns which would require significant input from both sides to be resolved. One centered on which drug-abusing parents were really appropriate for referral to the Project, with the new coordinator holding out for those who had demonstrated a real motivation to quit. However, DYFS staff — under pressure to refer every drug-abusing parent coming to their attention to some sort of treatment program — successfully opted for a more inclusive interpretation. Another concern centered on the possibility of utilizing any empty Project beds for Hudson County’s own emergency placement purposes; but the new coordinator preferred expanding the Project’s catchment area to accept boarder babies from other counties — a plan which was ultimately adopted.

² To make this analysis, we extracted data from a monthly boarder baby census compiled independently by Jersey City Medical Center’s social work department, for the period between October 1991 and April 1995. These data identify, month by month, which children were staying at JCMC and when each was born, most recently admitted, initially cleared for discharge, and finally discharged from the hospital. By aggregating the segments describing each child’s hospitalization across the months that he or she was an inpatient, we constructed a unique record for each child which designated:
  o the month in which the child was first determined to be medically ready for discharge;
  o the child’s age at the time he or she was medically cleared; and
  o how long the child remained an inpatient after being deemed ready for discharge.
In April 1992, the Project had two children under care — with one staying at the interim transitional residence. With the actual transfer of boarder babies from the hospital to cribs at the interim facility, the absence of a registered nurse on-site rapidly took on greater significance since the babies were fragile, with a wide range of problems requiring medication and medical follow-up; and a major impasse developed around the administration of medication. While the Project's child caregivers were clearly prohibited from dispensing any form of prescription medicine to residents, the State Board of Nurses argued that such non-medically trained personnel should be prohibited from administering any medication — even, for example, Tylenol — to Project children.

Almost in spite of these concerns, the Project shifted into higher gear in May; and by the end of the month, there were four children under care at the interim facility. However, the increased caseload served to clarify the fact that on-site management issues as well as the larger organizational issues — not only between JCMC and Project staff, but also between DYFS county and regional staff, on the one hand, and JCMC and Project staff, on the other — were taking their toll. The program coordinator soon came to a predictable parting of the ways with those responsible for the Project at both the Medical Center and DYFS. While there were hard feelings, all around, the departure of the coordinator as well as reassignment of DYFS's chief liaison to the Project — and the transfer of their respective responsibilities to others — provided a convenient excuse for the key actors to try to resolve their differences.

During June 1992, the Project continued with four children under care at the interim transitional residence. In-depth interviews with Project staff following the departure of the former program coordinator revealed that the transition had not unduly impacted staff morale — in contrast to what might have been anticipated. In fact, staff appeared motivated and committed to the Project's success and not negatively affected by the former coordinator's absence. An air of cautious optimism prevailed, as they awaited the arrival of his replacement.

By early summer, the Project had designed a curriculum, and begun accepting referrals from DYFS's three Hudson County district offices, for a series of parenting skills classes to be conducted, in both Spanish and English, by Project staff over the next few months. Close to 45 referrals from DYFS were accepted; and almost half of those referred actually attended at least one of the sessions, as did several parents and relatives of infants residing in the interim facility. However, it eventually became clear to all concerned that, while this effort — much like the Project's initiatives around SHSP family recruitment and teenage pregnancy and drug-abuse education — consumed a disproportionate amount of time and energy, Hudson Cradle staff were not all that effective at community outreach and training. Ultimately it was decided that these functions should be delegated to others with more expertise.

In July, the new program coordinator, a masters-level registered nurse, specializing in maternal/child health, arrived. By the end of the month, there were five children under care at the interim facility, and there were three more children on the waiting list for screening and possible intake. Around the end of August, there were four children under care at the interim transitional residence site; and there was one more child at the Medical Center itself. The new program coordinator had initiated a process of redefining and clarifying staff roles and responsibilities; and staff were undertaking realigned functions. A professional social worker was brought on board and assigned the responsibility of coordinating Project admissions and supervising the assistant social worker and substance abuse educator positions. Under the
new plan, staff were to conduct less parent training and to spend more time coordinating parent visitation with DYFS as well as supervising the parents during their visits. Moreover, each child staying at the facility was now assigned a primary infant caregiver, and the need for accountability and up-to-date documentation was being emphasized with these assignments. Finally, a program of ongoing staff training around child development — as well as nutrition, safety, medication, and HIV infection — was implemented.

Throughout September and October 1992, there were four to five children at the interim facility. Over the preceding 15 months, from August 1991 through October 1992, the Project had cared for a total of 14 boarder babies, while staff at times provided services to their birth mothers as well as to a few of their fathers and other relatives. In addition, the Project more indirectly had served another 17 children, whose parents were referred by DYFS and had participated in the parenting skills training classes run by the Project.

It was not until several months later, in early 1993, that construction was finally completed on the permanent facility. After several delays caused by severe winter weather, the Project finally moved into its new quarters in March 1993. From then through August 1993, the Project’s census fluctuated substantially from month to month, varying from as few as one or two infants on-site to as many as nine.

Over its first two years, from August 1991 through July 1993, the Project had housed and cared for a total of 34 infants — far fewer than had been estimated originally. In subsequent years, the number of children staying at Hudson Cradle increased dramatically, rising to at least 30 new intakes each year and to as high as 42 during the period of August 1995 through July 1996. This trend is presented graphically in Chart 2, in which the bars represent the number of new children who were admitted to Hudson Cradle during each 12-month period, from August 1991 through July 1997; and the line represents the cumulative number of children who had stayed on-site through the end of that particular period.

While the staffing pattern was evolving over the life of the Project, one constant had been the specially-selected hospital attendants who served as infant caregivers, providing the bulk of the 24-hour direct care in Hudson Cradle’s residential facility. Originally, nine of the caregivers were full-time employees of the Project; and three, per diem, to cover weekends and absences. Because the hospital attendant positions were unionized, individual compensation levels exceeded the area’s market rate for comparable positions in group home settings. As a consequence, the caregivers comprised a relatively stable group from the Project’s inception. Initially, they were supervised by three licensed practical nurses — one for each weekday shift.

The Project’s principal focus has remained on the infants under its care, with an increased emphasis on assessing and addressing their developmental needs; but a greater effort was made to reach out to their birth parents and other relatives — not just when they came to visit the child at the facility, but also in their own homes and communities. A registered nurse and social worker were constituted into a family outreach team, to provide case-management, counseling, teaching, and skill-building services to the families of resident infants. And, Project staff began offering to transport clients to services to which they had been referred and even attempted home visits at times.
During the past year, the number of licensed beds at the facility was reduced to seven. Most months, there were few, if any, slots available for new intakes. As a result, DYFS's ability to identify appropriate placement resources — be they parents, relatives or foster homes — and to move each child out after a reasonable period of time became a pressing concern; and this, in turn, generated new tensions between the agencies.

As of July 31, 1997, a total of 169 boarder babies and other infants had stayed at Hudson Cradle. (Three of these children had stayed at the facility more than once, returning after having been discharged either for respite care or for an emergency placement following a foster care disruption.) These 169 children, and their birth and foster families, are the subjects of the evaluation report which follows.
B. METHODOLOGY

The objective of this evaluation is to identify the implications of the Hudson Cradle Project for the larger service delivery system statewide. The following general questions are being addressed, in order to achieve the overall purpose of this study:

1. Who were the boarder babies and families served by Hudson Cradle?

2. What services were offered to boarder babies and their families by Hudson Cradle, DYFS, and other providers with linkages to the Project?

3. Were the Project's goals achieved, and did this lead to improved infant and family functioning and the achievement of permanency?

4. What is the potential for incorporating successful Project components into the State's larger service delivery system?

1. Research Approach

This evaluation relied on both qualitative and quantitative methods. In assessing Project implementation and coordination, the principal investigator was assisted by a psychologist accustomed to dealing with a variety of public and private providers. In documenting service delivery, materials maintained in DYFS and Project case folders were scheduled for periodic review; and case-specific data extracted from these folders were linked together and entered into a computerized database, then processed and analyzed, using programs previously developed for similar studies. The evaluation plan incorporated a data collection strategy which is briefly described below.

1.1 Survey Hudson Cradle, JCMC and DYFS Staff

Members of the evaluation team spent a number of days on-site at various Project locations, observing operations, reviewing materials, and interviewing staff. Observations and opinions of the directors and staff of the Project — including those at DYFS, the Hudson Cradle facility, and the Jersey City Medical Center — were solicited via personal interviews and informal discussions which took place in the offices of respondents or over the telephone. Project implementation was, by and large, the main topic addressed in these interviews during the first two years of the evaluation.

1.2 Collect Data on Project Infants and Birth Parents

Data were collected, to be entered into a computer file, then edited and analyzed, describing the characteristics and service histories of the infants served by the Project. Medical and developmental data were extracted from copies of the relevant portions of the babies' hospital records, which were made available to Project staff, who in turn provided access to the information to the evaluation team. Other service data were extracted from the
case plan and placement histories kept at Project and DYFS district offices. The collected data were entered onto two kinds of forms: a chronological Case Data Form, comprised of monthly segments; and an Initial Intake Characteristics Form. Computerized case histories were constructed for all 169 infants transferred into the care of Hudson Cradle through July 1997, covering maximally a period starting sometime around when an infant was placed on social hold in the hospital through his or her Hudson Cradle stay and subsequent discharge, until the child’s case was finally closed by DYFS — or until July-August 1997, whichever occurred first.

Similarly, data were collected for a computer file describing the baseline demographic characteristics and other traits — when known — of the infants' birth parents. These data include gender, age, ethnicity, living arrangement, educational level, income sources, and social and medical problems. In this regard, it should be noted that there are 15 sets of siblings among the 169 infants who stayed at Hudson Cradle, including twelve sets of two and three sets of three children. Among these were six sets of twins and another pair of siblings admitted to the facility together. In our profiles of the birth mothers, the unit of analysis is based on the child; so we double-count the mothers of sibling sets. This is necessary to the extent that some characteristics (e.g., age, income, living arrangement) have changed from one intake to the next. Monthly programmatic data tracking the interaction between birth parents and other family members, on the one hand, and Project and DYFS workers, on the other, were also collected, from case records. These data, which monitored the frequency and types of caseworker-family contacts, services offered, and presenting problems, were appended to the records for the children themselves, to provide a month-by-month summary of DYFS and Project activities on behalf of the children served on-site and their birth families.3

The composite case histories of the 169 Hudson Cradle children encompass, through July-August 1997, almost 3,850 monthly segments — or, case-months — during which the child was under DYFS supervision, including close to 600 months in which the child resided at least part of the time in the Hudson Cradle facility, accordingly:

<table>
<thead>
<tr>
<th>TIMEFRAME</th>
<th>CASES</th>
<th>CASE-MONTHS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitalization before Hudson</td>
<td>121</td>
<td>163</td>
</tr>
<tr>
<td>Cradle Intake</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stay at Hudson Cradle</td>
<td>169</td>
<td>581</td>
</tr>
<tr>
<td>DYFS-active Period after</td>
<td>156</td>
<td>3,098</td>
</tr>
<tr>
<td>Leaving Hudson Cradle</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>169</td>
<td>3,842</td>
</tr>
</tbody>
</table>

3 The evaluator produced a codebook containing the forms, data collection protocols, and coding conventions used for this study: Jersey City Border Baby Study Evaluation Codebook, February 1992.
Forty-eight of the children's computerized case histories contain no pre-Hudson Cradle monthly segment. These children were either placed directly into Hudson Cradle without a prior hospitalization (n = 22) or were discharged from a hospital into Hudson Cradle during the same month they had been born or admitted (n = 26). The other 121 children account for some 163 pre-Hudson Cradle monthly data segments — an average of 1.4 case-months each. At the other extreme, 13 of the 169 children either had their DYFS case closed in the same month that they were discharged from Hudson Cradle; or else they still remained on-site or had been discharged from Hudson Cradle during the last months for which data were collected, July-August 1997; so their computerized case histories contain no monthly segments depicting a period of DYFS supervision after Project discharge. The other 156 cases do contain a total of 3,098 such segments — an average of just under 20 case-months each of DYFS supervision after leaving Hudson Cradle. The duration of DYFS supervision for seven of these children incorporates at least one DYFS case closing and re-opening subsequent to their discharge from Hudson Cradle. (And, in three of these seven situations, the child’s case had been re-closed, once again, prior to July-August 1997.)

1.3 Collect Data on a Comparison Group of DYFS Cases

Baseline demographic and monthly service data were also extracted from the DYFS case files of 16 infants previously on social hold who had been discharged from Jersey City Medical Center during the period of September through November 1991 — who, while they did not receive services from Hudson Cradle, nevertheless comprise a group of children closely matching those who did eventually receive such services. Since members of this comparison group were all discharged from JCMC in 1991, whereas a substantial proportion of the children served by the Project who are included in this study were discharged from the hospital to Hudson Cradle from 1995 through mid-1997 — when we stopped collecting data — the case histories of the comparison group children tend to be longer than those who stayed at Hudson Cradle more recently.

2. Organization of this Report

Findings from the evaluation are reported on, below, in two ways. First, we provide statistical profiles of the 169 children and their birth parents who were served by the Project. Then, we describe the problems they presented to, and the services they were referred to and/or provided by both DYFS and Hudson Cradle staff, during each of the three timeframes delineated in Table A, above. Secondly, we compare the case histories of a subset of these children with those of the group of 16 similar children who were not served by Hudson Cradle, to gain some understanding of the Project's potential impact. Finally, we attempt to tie together what we have learned from these analytical exercises with what we observed on-site, into a set of conclusions about the Project’s approach.
C. FINDINGS

Hudson Cradle provides 24-hour care, early intervention and infant stimulation, specialized and routine pediatric medical care, and outreach services, for babies and other infants and their families. In keeping with the Project's original plans, Hudson Cradle also recruited potential foster parents for DYFS; provided education around prematurity, HIV and prenatal drug exposure to a number of the agency's SHSP foster parents; participated in community forums offering information about pregnancy and substance abuse to Hudson County residents; and conducted parenting skills training classes for birth parents. These early programmatic initiatives, which have been reported on elsewhere, were subsequently de-emphasized in favor of an even greater concentration on what was seen as Hudson Cradle's primary mission: achieving permanency for boarder babies and other infants in out-of-home placement. The analysis that follows is itself focused on that portion of Hudson Cradle's and DYFS's activities which addressed the problems, needs, and changes in the lives of those boarder babies and other infants cared for on-site at Hudson Cradle, and their birth parents, relatives and foster parents.

1. Profiles of Those Served

Perhaps the most logical place to start this analysis is with the birth mothers and — to much less a degree, due primarily to the paucity of information about them — the fathers of the 169 children admitted into Hudson Cradle through July 1997.

1.1 The Birth Mothers

Chart 3 presents a demographic picture of the birth mothers. At the time her child was being referred to the Project, one in twelve of these mothers was a teenager; a fifth were 20 to 24 years old; and almost three-fifths were 25 to 34. Their median age was 28 years. At the extremes, two of the mothers were 13 to 15 years old; and four were 40 to 41. Two in three of these mothers are African-American; a fifth, Hispanic; and the rest, White. While information describing the mother's educational attainment is missing from about one record in four, it seems that close to a tenth had attended college; while almost another fifth had graduated high school. Over half were high school dropouts; while another fifth apparently never even got past the eighth grade. Well over 90 percent are American citizens, so place of birth — and age, for that matter — would not seem to offer much in the way of an explanation for many of the mothers' exceptionally low educational attainment.

At the time of their child's referral to Hudson Cradle, between a fourth and a third of the mothers were living in an apartment with the birth father. (Information about the fathers is sketchy; but it would seem that their median age was around 33 and that their average educational level was higher than the mothers'.) One in ten mothers lived in her own apartment — often with one or more of her children; while another fifth lived with their parents or

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CHART 3. PROFILE OF CHILD'S BIRTH MOTHER
Children Who Stayed at Hudson Cradle
(8/91 - 7/97)

CHART 4. PSYCHOSOCIAL PROBLEMS
OF CHILD'S BIRTH MOTHER
Children Who Stayed at Hudson Cradle
(8/91 - 7/97)
other relatives. Over a fourth of the mothers were homeless; and, of these, more were actually on the street than were temporarily living at a shelter or welfare hotel. The rest were fairly evenly split between those sharing quarters with non-relatives and those who were incarcerated.

Half of the birth mothers — including virtually all those who were homeless — had no known income (not shown in Chart). Four-fifths of the others were mainly dependent on welfare or other transfer payments. Between a fifth and a fourth of the mothers were in a household with at least some employment income; perhaps as many as half the fathers with whom the women were living worked or had recently been employed at least part-time, as was true of one in ten of the women themselves.

Many of the mothers had a psychosocial history which could readily be interpreted as indicating potential risk for their children. Chart 4 shows the incidence of some of these factors. Two-thirds of the infants’ mothers had been abusing drugs and alcohol for many years prior to their most recent pregnancy. One in five had a serious medical condition, including tuberculosis and AIDS; one in ten had a history of psychiatric treatment and/or hospitalization; and, a seventh were reported as having other significant physical or mental handicaps, such as deafness, mental retardation, and cerebral palsy.

Four-fifths of the birth mothers were already known to DYFS; they had at least one prior allegation of child maltreatment registered against them. Over half had been accused of child neglect (not shown in Chart). A third had been reported for not providing adequate food or shelter for their children; and a fourth, for inadequately supervising their children. A sixth had been accused of abandoning a child or leaving a young child home alone; and roughly the same proportion had allegedly used excessive force in disciplining a child. Under a tenth each had allegedly injured a child much more seriously through physical or sexual abuse.

Some 144 of the mothers had given birth to one or more children prior to the infant who was referred to Hudson Cradle. More than two-fifths of all the mothers — or, more appropriately, over half of those with older children — had previously had a child removed from their home and placed in substitute care. At the time their most recent child was referred to Hudson Cradle, over a quarter of the birth mothers still had at least one child in placement.

With all this in mind, it should come as no surprise that most of the mothers were not living with their children. Just over a third of the birth mothers who had older children were, in fact, living with at least one of them around the time that their youngest was being referred to DYFS and Hudson Cradle. (See Chart 5, top, for a distribution of how many children the birth mothers had in placement.) Of the total of 434 older children, just under a fourth were living with their mother at the time; and just over a fourth were in some kind of foster care arrangement. The remaining half were with living another relative.

Needless to say, many of the birth mothers already had an active DYFS case when their most recent child was born. The new child was referred to DYFS, in three out of four cases, by a hospital social worker — usually soon after birth. In those cases where someone else referred the case, the child usually was older, had already been released to its mother following birth, and was now being readmitted to the hospital following an injury, illness, or episode of child abuse or neglect. The reasons for the children’s DYFS referrals are shown in Chart 5,
CHART 5. DYFS INVOLVEMENT WITH FAMILY AT TIME OF REFERRAL
Children Who Stayed at Hudson Cradle (8/91 - 7/97)

# OF OLDER SIBLINGS ALREADY IN PLACEMENT
0
1
2
3+

CHILD REFERRED BY
hospital
family member
police
other

PRINCIPAL REASON FOR REFERRAL
maternal drug abuse
abandonment
other child neglect
child abuse
inadequate housing
parental incapacity
parental request

% with specified characteristic

CHART 6. BIRTH-RELATED RISK FACTORS
Children Who Stayed at Hudson Cradle (8/91 - 7/97)

THE MOTHER WHILE PREGNANT...
used cocaine
used heroin
used alcohol
used other drugs
had a STD
was HIV-positive
had no prenatal care

THE BABY... was born prematurely
34 - 36 weeks
31 - 33 weeks
up to 30 weeks
had low birth weight
up to 3.4 lbs
3.4 - 5.5 lbs

% with specified characteristic
bottom. In about two-fifths of the cases, the referral was based strictly on the mother’s having abused drugs while pregnant — most often following a positive toxicology report on the baby’s urine screen, but sometimes because the mother and her addiction were already known to hospital staff. A sixth of the referrals involved an allegation of child abandonment, usually because the mother left the hospital — and her baby in it — shortly after giving birth. Referrals based on child abuse and neglect — about a fifth of the total — often concerned somewhat older children being readmitted to the hospital or cases that had been opened even before the mother gave birth, while she was still pregnant. One in eight referrals was made because hospital staff either knew a mother was homeless and did not want to discharge her baby until she had secured adequate quarters or felt that a mother had demonstrated poor self-care and was mentally or physically handicapped in a way which would impact significantly on her parenting abilities. A tenth of the cases were, in effect, self-referred inasmuch as the mother had requested that her child be placed from the outset.

DYFS generally puts a great deal of emphasis on its workers’ securing a voluntary agreement — where the parents concur in the placement decision — although the process of arriving at this conclusion can take a considerable amount of time. About three in five Hudson Cradle placements did, in fact, follow such a voluntary agreement — the remainder being court-ordered. (In a couple of cases, parents who voluntarily agreed to placement had a subsequent change of heart.)

1.2 The Project Children

In Chart 6, some of the more obvious risk factors related to the children’s births are displayed. Five in six of their mothers abused drugs or alcohol while pregnant. A third had used alcohol in conjunction with a controlled substance; only a couple had abused alcohol but no controlled substance (not shown in Chart). Just under two-fifths were polydrug — not counting alcohol — users. Seven in ten mothers had used cocaine — generally in the form of "crack" — while pregnant; and the urine screens of half the babies tested positive, at birth, for cocaine toxicology. Three in ten had used heroin — with its use climbing among the more recent cases. Over a fourth of the mothers had abused other drugs, often in combination with one of the above. Among these — in descending order of use — were marijuana, methadone and barbiturates.

One in eight babies had been exposed by their pregnant mother to a sexually transmitted disease ("STD") — typically syphilis or chlamydia. A sixth of the babies had been born HIV-positive; but three-fifths of these seroreverted and turned out not to be infected by the AIDS virus — although their mother clearly was. Almost two-thirds of the mothers reported that they had received no prenatal care at all; most of the rest visited a doctor or clinic just one to three times — and, generally, later in their pregnancy.

Two in five babies were born prematurely; one in six, by a month or more. Similarly, half of the children had a low birth weight (under 2500 grams); and one in eight, a very low birth weight. The median birth weight of all the children was 2505 grams; but it ranged all the way from just under two pounds to more than eleven pounds. Prematurity and low birth weight are both highly significant predictors of a child’s future health and developmental risk.
Chart 7 depicts the post-natal histories of the babies. Half experienced various neonatal complications — most commonly respiratory distress, but also apnea, sepsis, tachycardia, bradycardia, congestive heart failure, convulsions and seizures — and a couple almost died. Close to two babies in five exhibited symptoms of drug withdrawal — like extreme irritability, jitteriness, and tremors — for a time after birth; and two-fifths of these had to be treated to alleviate their distress, usually with phenobarbital from ten days to two weeks or more. A fifth of the babies also had congenital abnormalities that were noted relatively soon after they were born, ranging from relatively mild eye and facial anomalies to chromosomal deficiencies and neurological and skeleto-muscular conditions (not shown in Chart).

As a result of both their medical circumstances as well as the social hold under which almost all the children were placed after birth, the typical infant referred to Hudson Cradle experienced a prolonged neonatal hospitalization. Their median neonatal hospital stay lasted 31 days. A sixth stayed in the hospital for less than a week; and a fifth, for more than two months. (Only six babies actually remained hospitalized for over three months.) A fourth of the Project's children finally left the hospital, following birth, with their mother or — in a handful of cases — another relative; and all the rest, except for a couple who first went into a foster home, were discharged directly into Hudson Cradle. Most of those who had gone home with a mother or relative were soon thereafter re-hospitalized, placed on social hold, and then, ultimately, referred to the Project. If we combine these later hospital admissions with the neonatal stays of the babies who were referred directly into Hudson Cradle, we find that a fourth of the 147 children who were discharged into Hudson Cradle from a hospital had just spent up to a week as an inpatient on social hold and medically cleared for discharge; and another fifth, more than a month (not shown in Chart). The median number of medically cleared days that these children had just remained in the hospital was 16 — over two weeks; and, on average, this accounted for half of the total time they had been hospitalized before their Hudson Cradle intake.

Chart 8 displays a profile of all 169 children at the time of their admission to Hudson Cradle. There are more boys than girls in the group and — as we would expect from having already seen a profile of the mothers — many more African-Americans than members of other racial/ethnic groups. At intake, a fourth of the children were under a month old; and almost a third, from one to two months old. Close to a fifth were over a half-year old on admission; and the oldest four were between a year and a half and two years old. Most of the "older" children were those who initially had been discharged from the hospital in the care of a family member.

2. Problems and Services Before Hudson Cradle Intake

As already indicated, the parents of the children admitted to Hudson Cradle had problems, in a variety of areas, that needed to be addressed even before being referred to the Project. Charts 9, 10, and 11 describe the family situations of the 121 children with a pre-Hudson Cradle service history — generally while they were still hospitalized and on social hold. We examine these situations in terms of the needs of, contacts with, and services offered to, their birth parents and other key relatives — either directly by DYFS staff or else through referral to outside agencies for the appropriate assistance. (Since the data upon which these statistics are based were extracted from DYFS case folders, it must be kept in mind that the picture which emerges is from the perspective of that agency's own staff.)
CHART 7: CHILD'S HOSPITAL EXPERIENCE FOLLOWING BIRTH
Children Who Stayed at Hudson Cradle (8/91 - 7/97)

<table>
<thead>
<tr>
<th>HAD DRUG WITHDRAWAL SYMPTOMS:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>treated</td>
<td></td>
</tr>
<tr>
<td>untreated</td>
<td></td>
</tr>
</tbody>
</table>

HAD OTHER NEONATAL COMPLICATIONS

<table>
<thead>
<tr>
<th>STAYED IN HOSPITAL:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>up to 7 days</td>
<td></td>
</tr>
<tr>
<td>8 - 15 days</td>
<td></td>
</tr>
<tr>
<td>16 - 30 days</td>
<td></td>
</tr>
<tr>
<td>31 - 60 days</td>
<td></td>
</tr>
<tr>
<td>61+ days</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>WAS DISCHARGED TO:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>biological parent</td>
<td></td>
</tr>
<tr>
<td>other relative</td>
<td></td>
</tr>
<tr>
<td>Hudson Cradle</td>
<td></td>
</tr>
<tr>
<td>foster home</td>
<td></td>
</tr>
</tbody>
</table>

% with specified characteristic

CHART 8. PROFILE OF CHILD
Children Who Stayed at Hudson Cradle (8/91 - 7/97)

<table>
<thead>
<tr>
<th>GENDER:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>male</td>
<td></td>
</tr>
<tr>
<td>female</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>RACE/ETHNICITY:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>African-American</td>
<td></td>
</tr>
<tr>
<td>Hispanic</td>
<td></td>
</tr>
<tr>
<td>White</td>
<td></td>
</tr>
<tr>
<td>Bi-ethnic</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>AGE AT HUDSON CRADLE INTAKE:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>up to 30 days</td>
<td></td>
</tr>
<tr>
<td>31 - 60 days</td>
<td></td>
</tr>
<tr>
<td>61 - 90 days</td>
<td></td>
</tr>
<tr>
<td>91 - 182 days</td>
<td></td>
</tr>
<tr>
<td>182+ days</td>
<td></td>
</tr>
</tbody>
</table>

% with specified characteristic

18
Overwhelmingly, the main presenting problem noted — in over half of these cases — centered around the parents' substance abuse. In a fourth of the cases, housing was also reported to be a major consideration; and in a fifth, medical issues — either the child's or a parent's. Although there was a smattering of other problems noted, no single problem accounted for a substantial share of cases. (See Chart 9.) Interestingly, while a significant number of the birth parents were facing a child abuse/neglect action in Family Court, this process did not appear to take on any immediacy in most case records. The whereabouts of eight mothers was unknown during all or part of their child's hospitalization; they had, for all intents and purposes, abandoned the child in the hospital.

DYFS caseworkers managed to contact a family member in the vast majority of cases. During the time immediately preceding each child's Hudson Cradle intake, a DYFS caseworker personally met with some family member — generally, at least once or twice with the birth parents — in six of every seven cases (not shown in Chart). The frequency and types of contact between DYFS and the child's family are shown in Chart 10. (The unit of analysis here is not the 121 cases but rather the 163 case-months leading up to the children's Hudson Cradle intakes.) Home visits or other contacts in the field — often, in the hospital itself — between caseworkers and family members occurred in three out of every four months immediately before the child was admitted to Hudson Cradle. In 40 percent of the months, there was just one of these contacts; in 20 percent, two; and, in 15 percent, few, three or more. Other in-person contacts between caseworkers and the family took place in the DYFS district offices; but these occurred much less frequently — in about one month out of six. And, there was at least one telephone conversation between the worker and family in about half the months.

Many of the birth mothers visited irregularly with their children while they were hospitalized. Nevertheless, much of the caseworkers' early efforts — once the child was placed on social hold — centered on keeping the birth parents in touch with the child and arranging for a more formal visitation schedule. These efforts were largely unsuccessful, as shown in Chart 10, bottom. The fathers hardly complied with the visitation schedules at all. The mothers officially visited their child in only of every six months — although those who did visit tended to come more than once a month. No sibling visits and very few visits by other relatives were reported during the DYFS case's early months; but this is not unexpected since caseworkers' initial efforts tend to be focused on birth parents.

Chart 11 shows the various kinds of services case members were provided or referred to during the child's hospitalization. Except for referring birth parents to a drug treatment program, in about a fifth of the cases, DYFS caseworkers managed to add little to the inpatient medical care which the child was already being provided while on social hold. In sum, during the period leading up to a child's admission into Hudson Cradle's residence, while the DYFS worker assigned the case tended to see a birth parent most months and to recognize that the parent needed help, at the very least, around substance abuse and/or housing — both of which problems are not easily susceptible to quick solutions — the worker nevertheless tended to arrange for few services and to facilitate few visits between the parent and child. Three explanations have been offered for this low level of service provision. First, the early phase of any new case generally is focused on investigating the situation and developing a case plan rather than on arranging for services. Second, the life styles of most of the parents — involving homelessness and drugs — makes them a particularly difficult group to engage. And third, many of these families had a prior experience in which DYFS either threatened to or actually
**CHART 9. PROBLEM AREAS IN MONTHS BEFORE CHILD ENTERED HUDSON CRADLE**
Children Who Stayed at Hudson Cradle
(121 cases, 8/91 - 7/97)

- child abuse
- child neglect
- Family Court
- interpersonal
- criminal justice
- financial, employment
- housing
- school, child care
- disability
- medical
- mental health
- substance abuse
- mother pregnant
- mother unlocatable

% of cases in which problem was noted

**CHART 10. PERSONAL CONTACTS IN MONTHS BEFORE CHILD ENTERED HUDSON CRADLE**
Children Who Stayed at Hudson Cradle
(163 case-months, 8/91 - 7/97)

- CONTACT BETWEEN DYFS WORKER AND FAMILY MEMBER
  - at home or in field
  - in district office
  - by telephone

- VISITS WITH CHILD
  - by mother
  - by father
  - by relative
  - by sibling

% of months in which contact was noted
did remove a child from their care; so they might well have been disinclined to cooperate with
the agency's workers in matters involving another of their children.

3. Problems and Services While at Hudson Cradle

Once at Hudson Cradle, the children's stays ranged from 3 days to just over 8 months. (See Chart 12.) Some 169 children had been admitted by July 31, 1997, and all but one had been discharged by the following September 30th. The median stay at the residence for these 168 children was 60 days. One in twelve discharged children lived at the facility for no more than half a month; and another seventh, for up to a month — not a great deal of time for program staff to effectuate a significant change in their lives.

While the children were staying at Hudson Cradle, the preponderance of parental substance abuse as one of the main problems reported for their cases decreased only negligibly from its level for the prior period; but housing — as with almost every other problem area reported — took on greater saliency in the families' cases. (See Chart 13.) It is important to remember that the differences in problems noted in the case record do not necessarily reflect actual changes in parental behavior but rather a shift in the issues on which the caseworkers were focusing their attention. In keeping with this thought, Family Court proceedings — which generally assume a high priority for caseworkers — now became the chief problem area being addressed. The time had arrived — or, at least, was drawing near — for establishing paternity for some children, concluding negotiations around a placement agreement, and completing a case plan with recommendations for the near term; and the Family Court was the forum in which such decisions would be ratified and any loose ends resolved. Child abuse or neglect allegations — often stemming from the investigation into the current case — occupied family members in between a tenth and a sixth of the cases. Medical problems were reported in close to a third of the cases; and financial problems — generally related to securing welfare or other assistance — were addressed in a fifth. Criminal justice issues — usually, a mother being arrested and jailed for a drug-related crime — characterized one in five or six. In a sixth of the cases, the birth mother was unlocatable for some portion of the time that her child was staying at Hudson Cradle; and in an equal proportion of cases, family members reported having an interpersonal problem — typically either between the child’s mother and father or between one of them and their own parents or siblings.

While the children resided in the facility, members of their family might be contacted by workers from DYFS or Hudson Cradle; and they could be offered services by either or both. In fact, workers from the two agencies managed to be in contact with family members in all cases but four and personally met with members in all but seven cases during this time. The frequency and types of contact between DYFS, Hudson Cradle and the child’s family are shown in Chart 14. (The unit of analysis here is the total 581 case-months during which the 169 children stayed in Hudson Cradle, through July 1997.) Home visits or other contacts in the field between DYFS caseworkers and family members occurred in half the months — much less often than during the period before the child was admitted to Hudson Cradle. Hudson Cradle workers, in contrast, rarely visited a family member outside the office; however, the two would meet at the facility in over half the months that the child was in residence. In fact, most of these meetings coincided with the family member’s visiting the child. Comparable in-person contacts between DYFS caseworkers and the family took place in the district offices;
CHART 11. SERVICES OFFERED IN MONTHS BEFORE CHILD ENTERED HUDSON CRADLE
Children Who Stayed at Hudson Cradle
(121 cases, 8/91 - 7/97)

CHART 12. LENGTH OF CHILD’S STAY ON-SITE
Children Who Stayed at Hudson Cradle
(8/91 - 7/97)
CHART 13. PROBLEM AREAS IN MONTHS
WHILE CHILD WAS AT HUDSON CRADLE

Children Who Stayed at Hudson Cradle
(169 cases, 8/91 – 7/97)

- child abuse
- child neglect
- Family Court
- interpersonal
- criminal justice
- financial, employment
- housing
- school, child care
- disability
- medical
- mental health
- substance abuse
- mother pregnant
- mother unlocatable

% of cases in which problem was noted

CHART 14. PERSONAL CONTACTS IN MONTHS
WHILE CHILD WAS AT HUDSON CRADLE

Children Who Stayed at Hudson Cradle
(581 case-months, 8/91 – 7/97)

CONTACT BETWEEN WORKER AND
FAMILY MEMBER
- at home or in field
  - Hudson Cradle
  - DYFS
  - at office
- by telephone
  - Hudson Cradle
  - DYFS

VISITS WITH CHILD
- by mother
- by father
- by relative
- by sibling

% of months in which contact was noted
and these occurred in about one month out of five — slightly more frequently than during the
prior period. There were numerous telephone conversations between both DYFS and Hudson
Cradle workers, on the one hand, and various family members, on the other; and these
occurred in over half the months with each worker — at about the same rate with both and
about as often as in the prior period with the DYFS worker.

The rate at which the birth mothers visited their children increased dramatically from the
prior period, to a level where there was a visit at Hudson Cradle — and, more often than not,
several visits — in half the months, as shown in Chart 14, bottom. In fact, there was a total of
about 1,450 visits scheduled for these mothers while their child was staying in the residence;
and they kept almost 1,300 of these appointments. The fathers also visited more often — in
one of every four months during which the children were under care — and kept over 510 of
the almost 560 visits scheduled. The children’s other relatives — generally aunts, uncles and
grandparents — visited during more months than the fathers but at a lower overall frequency.
Sibling visits were usually arranged by DYFS.

Chart 15 shows what kinds of services case members were provided or referred to
during the child’s stay at Hudson Cradle. The Cradle arranged for all its children to receive
periodic well-baby care, as well as treatment through JCMC for any illnesses or chronic
conditions. Three in four children required a referral to a doctor or clinic for special medical
attention during their stay; and one in six had to be re-hospitalized for some period of time (not
shown in Chart). All the children but the dozen or so with the shortest on-site stays were
given a developmental evaluation; and half received formal early intervention services —
speech, occupational and/or physical therapy — in addition to the regimen of less formal
developmental services — infant massage and floor play — that all children received while at
Hudson Cradle. The need for early intervention is highlighted by the fact that two-thirds of the
children were diagnosed as having a developmental delay or problem in at least one area at
some point during their early life. The distribution of these diagnoses is shown in the following
table:

<table>
<thead>
<tr>
<th>Area of Delay</th>
<th>% Diagnosed</th>
</tr>
</thead>
<tbody>
<tr>
<td>fine motor</td>
<td>38</td>
</tr>
<tr>
<td>gross motor</td>
<td>37</td>
</tr>
<tr>
<td>expressive speech</td>
<td>41</td>
</tr>
<tr>
<td>receptive language</td>
<td>36</td>
</tr>
<tr>
<td>personal/social</td>
<td>27</td>
</tr>
<tr>
<td>muscle tone, reflexes</td>
<td>29</td>
</tr>
<tr>
<td>other</td>
<td>33</td>
</tr>
</tbody>
</table>

Table B. Developmental Problems

Ever Diagnosed among Project Children

24
CHART 15. SERVICES OFFERED IN MONTHS WHILE CHILD WAS AT HUDSON CRADLE
Children Who Stayed at Hudson Cradle
(169 cases, 8/91 - 7/97)

CHART 16. TO WHOM WAS CHILD DISCHARGED FROM HUDSON CRADLE
Children Who Stayed at Hudson Cradle
(8/91 - 7/97)
DYFS provided emergency assistance for the overwhelming majority of cases, usually in the form of a clothing check for the child. The parents of between two-fifths and half the children were assisted with referrals and follow-up to drug-abuse treatment and rehabilitation programs and with transportation either in the form of carfare or a ride with their DYFS or — less frequently — Hudson Cradle caseworker. Otherwise, during the time the child stayed at Hudson Cradle, no single service was arranged for more than a fifth of the cases; and few families were helped in their effort to secure adequate housing despite the prevalence of this problem.

Relatively few of the children left Hudson Cradle to be with their birth families. (See Chart 16.) Of the 168 discharged children we studied, only a tenth went directly to a birth parent from Hudson Cradle — 13 to the mother and three to the father. Between a sixth and a fifth went to other family members. Of the remaining children, two were so sick that they had to be discharged back into the hospital; and 71 percent went into foster care. Among this latter group, two in five were classified as medically fragile or had other special needs that necessitated their being placed in a SHSP home rather than with a regular foster family; and a couple were discharged directly into a pre-adoptive home.

In sum, when a child was at Hudson Cradle, the rates of family contact and child visitation increased substantially over those of the prior period, although the frequency and duration of the visits with children did not approach the levels which had been projected initially. Service provision rates rose as well, but more for the children than for their birth parents. In managing the cases at Hudson Cradle, there developed a general division of labor in which DYFS workers tended to see birth parents at their homes or elsewhere in the field and to arrange for most of the services that the parents received. Hudson Cradle workers, on the other hand, usually met a family member when he or she came to visit the child on-site and limited their interaction to counseling and various referrals — especially around substance abuse and parenting skills — while focusing more of their concern on the child’s needs. This inattention to the parents’ needs and the lack of concrete services offered to most by DYFS — at least during the Project’s early years — arguably contributed to so few of the children being reunited with family immediately following their tenure on-site. Other explanations have been offered as well, including the difficult lifestyles of the parents and the fact that DYFS had sole control over when a child was discharged and to whom; so Hudson Cradle staff often experienced difficulties in carrying out their own plans to strengthen family ties and promote reunification. Two additional points are that the Project’s social worker position was vacant, on and off again, for a number of months and that there was also no Spanish-speaking professional on staff during the early years at the facility.

4. Problems and Services After Leaving Hudson Cradle

Once they left the Hudson Cradle facility, we were able to track the children’s DYFS cases until either they were closed or we stopped collecting data in July-August 1997. As of July-August 1997, 79 of the children’s DYFS cases had been closed at least once; and 90 had not yet been closed. The period that children remained DYFS-active after leaving Hudson Cradle ranged from a couple of days to almost six years; and the median time that we were able to track these DYFS-active children was 474 days. Chart 17 depicts this information graphically. Each bar, which represents the percentage of Project children who remained
DYFS-active for the number of months specified below the bar, is divided into two segments: those whose DYFS case was closed within that period of time after leaving Hudson Cradle and those whose case had not been closed at least once as of July-August 1997. Over half the closed cases were terminated by DYFS within a year after the child left Hudson Cradle; and three-fourths, within two years. The longer cases remained DYFS-active, the less likely they were to be closed by the agency.

Once a child left Hudson Cradle, the staff there were no longer involved in actively planning for the case, although — starting about midway through the Project — they usually attempted to follow up for two or three months. At most, Project staff might follow through on a referral they had initiated; or they could be called on to arrange a visit to the Medical Center or to expedite a transfer of records. And, once in a while, a new foster parent might call for some information or assistance. Exclusive responsibility for the case reverted to DYFS; but, even within the agency, the lines of communication — if not those of authority — could become confusing. By July-August 1997, one in five Project children had spent some time in placement with a foster family living a substantial distance away from their birth family — i.e., in another county — usually because of the lack of a local SHSP home. This situation did, in fact, improve over time; a third of the children discharged from Hudson Cradle during its first two years spent time in a foster home away from their county of origin, as compared to a sixth of those who left Hudson Cradle afterwards.

After a child left Hudson Cradle, parental substance abuse was no longer likely to be considered by the caseworker as quite as dominant a problem as it had been in prior periods; while housing maintained roughly the same level of priority. Family Court proceedings now constituted the chief problem area being addressed, followed by medical issues and — to almost the same degree — concerns around children's day care and school arrangements. (See Chart 18.) Financial, criminal-justice, and interpersonal problems were each reported in between a fourth and a third of the cases. Almost two in five birth mothers were unlocatable for some portion of time after their child had been discharged from Hudson Cradle but was still DYFS-active, and one in five became pregnant again. Since these are the problems noted in the case record, they may reflect lower rates of caseworker-client contact as much as the reality of what the parents were actually experiencing.

There was a sharp decline in the frequency of contact between caseworkers and birth family members as well as in officially-scheduled child visitation during the months after a child was discharged from Hudson Cradle. During this time, DYFS workers contacted family members in every case but five and personally met with members in all but nine cases. The frequency and types of contact between DYFS and the child's family are shown in Chart 19. (The unit of analysis here is the total 3,098 case-months through July-August 1997 — the close of data collection — during which 156 children were DYFS-active after leaving Hudson Cradle.) Home visits or other contacts in the field between DYFS caseworkers and birth family members occurred in just under one out of every three months; and there were less likely to be multiple home or field contacts in a month than previously. Contacts between caseworkers and the family in a district office took place in about one month in nine; and telephone contacts, in just over one month in three.

The official rate at which the birth mothers visited their children dropped by more than half from the prior period at Hudson Cradle, as shown in Chart 19, bottom. However, this is
somewhat of a statistical aberration, since a number of children had been placed with family members; and, in such circumstances, DYFS tends to cede control over the amount of visitation that is going on. Also, as cases go forward, parental rights, including visitation, are likely to be abridged by the court. A more appropriate measure might be the proportion of DYFS-scheduled visits that were kept; but, even here, the rate dropped from the preceding period. Close to 1,500 visits were officially scheduled for the mothers; and they missed about one-third of these appointments. Fathers and relatives visited the children infrequently.

Chart 20 shows what kinds of services case members were provided or referred to after the child left Hudson Cradle. Medical care again predominated, in the form of periodic well-baby and follow-up examinations, as well as treatment through JCMC or another hospital closer to the child's home. As in the prior period, three children in four required a referral for special medical attention; and one in four had to be re-hospitalized for a time (not shown in Chart). Emergency assistance was dispensed in three out of five cases—generally, in the form of a check to a foster parent for a child's clothing, a crib or car-seat, or a family vacation, or in smaller amounts to a birth parent to meet an immediate crisis to help stabilize his or her life.

Two in five children were given another developmental evaluation; and close to half received early intervention services after leaving Hudson Cradle. Between two-fifths and half the children were at the point where they could be referred for day care or school-related assistance; and one-fifth, for respite care—often when foster parents went on vacation or had a personal emergency. And, a handful had begun individual therapy. Those birth parents who were more actively involved in trying to regain custody of their child were referred to appropriate services, like substance abuse rehabilitation, psychological evaluations and/or therapy, and support groups; and they were often transported for visits with their child. Home health aides were scheduled for over a third of the homes in which the children were living.

In sum, then, after a child was discharged from Hudson Cradle, overall rates of child visitation and contact between caseworkers and the birth family both decreased, although various services were more likely to be offered—at least once during the period—to both birth and foster parents. Several explanations were given for these findings. The transfer of many children out of the local area—both physically and administratively—had consequences for the level of contact that occurred thereafter, not only between children and their parents but also between DYFS caseworkers and various family members. Moreover, there was often a hiatus of several months while a child's records caught up with the new caseworker. And, on top of all this was the emotional "distancing" that was taking place between some families and children, as mothers became pregnant again, were jailed, or moved without notifying anyone of their new address. At the other extreme, some birth parents were cooperating with DYFS and going to great lengths to regain custody of their child; and a number of other family members had taken in a child so it would not end up in a stranger's home.

5. Achieving Permanency for Project Children

DYFS's overriding objective in offering the services enumerated above was to facilitate attaining permanency for Project children. Essentially, with the passage of time, involved family members were being forced to decide where they stood in relation to each child; and those who were unwilling or unable to subordinate their own pursuits to the needs of this child
were generally making it easy for DYFS to decide for them. As time passed, it was more and more likely that a child’s DYFS case eventually would be resolved and closed; he or she would end up living either with a parent or other relative or with an adoptive family.

In fact, during the year or two after children left Hudson Cradle, a progressively greater proportion of them were either returned to a family member or freed for adoption. (See Chart 21.) If we look at each child’s living arrangement six months after he or she had been referred to the Project, we find that two-thirds were still in foster care — including several still residing at the Hudson Cradle facility after a half-year. But, by a year after referral, just half the children were still in a foster home; and, as of July-August 1997, this proportion had dropped even further to just over a fourth. Conversely, the proportion in a pre-adoptive or adoptive home doubled from two percent at six months to 4 percent at a year, and then surged to 25 percent by the time we concluded collecting data for this study. Over the same period, those living with parents or other relatives rose from 32 percent to 44 percent, between six and 12 months, and then remained at this level — again reinforcing the notion that the best outcomes, vis-a-vis DYFS, tended to happen sooner rather than later.

While most of these changes in children’s living arrangements presumably resulted in positive outcomes by child welfare standards, it is important to bear in mind that they could only be accomplished by disrupting children’s current placements and physically moving them from one household and set of caregivers to another. And, this must be considered within the context that all the children had already been moved at least once before — when they were discharged from Hudson Cradle itself. Two in five Project children experienced at least one move during the period after they left Hudson Cradle through to the end of data collection. Twenty-four percent of the total were moved once; 12 percent, twice; four percent, three or four times; and one percent, even more. (Not shown in Chart.)

By July-August 1997, almost half the children’s DYFS cases had been closed and — perhaps more importantly — seven in ten children apparently had achieved, or were well on their way to, permanency. (See Chart 22.) Close to half were living with family members — although many were still under DYFS supervision. An eighth had a finalized adoption; and another eighth had been freed for adoption and were in a pre-adoptive home. Just over a fourth of the total were still in a foster home; and, finally, three of the children had died. Of those who had been reunited with a member or their birth family, the greatest proportion — two in five — were with one or both of their parents. The next biggest segment was with a grandparent; followed by those with an aunt or uncle; and then, those with a cousin, older sibling, or other relative.

If we examine where the children were living, as of July-August 1997, according to how many household moves they had experienced (not shown in Chart), we find that three-fourths of those who moved just once after leaving Hudson Cradle ended up with a birth parent (32%) or other relative (43%). They generally went first into foster care and then to a family member. Conversely, half as many of those who moved more than once ended up with a parent or other relative (38%); most were in a pre-adoptive or adoptive home (45%). And, among those who never moved, equal proportions were with a family member (36%) or still in foster care (38%) as of end the of data collection; and a fourth were in a pre-adoptive or adoptive home. Almost all of this last group had been discharged from Hudson Cradle into a foster home where they then remained — and which later agreed to adopt them.
CHART 21. CHILD'S LIVING ARRANGEMENTS AFTER REFERRAL TO HUDSON CRADLE
Children Who Stayed at Hudson Cradle (8/91 - 7/97)

CHART 22. CHILD'S LAST-KNOWN LIVING ARRANGEMENT
Children Who Stayed at Hudson Cradle (8/91 - 7/97)
Baseline demographic and monthly transaction data were extracted from the DYFS case folders of 16 boarder babies who had been discharged from Jersey City Medical Center in mid-to late-1991. These children received no services from Hudson Cradle; but we assumed that they would otherwise closely match, in terms of background, demography and health, those children who would be served. In fact, the 16 children were selected to comprise a kind of "control group," against whom we could compare what happened to Project children who closely match them: boarder babies who were discharged from a hospital into Hudson Cradle before December 31, 1993. Since the 16 children were all discharged from JCMC by the end of 1991, their case histories tend to be longer than most Hudson Cradle children (who were born later than they were). To adjust for this factor, we limited our comparison to a "treatment group" comprised only of the first 44 boarder babies served by the Project. While the major timeframes that demarcate cases in the treatment and comparison groups are not quite equivalent, neither are the differences statistically significant. Benchmark timeframes for the treatment group (n=44) and comparison group (n=16) are compared with each other and with those of Hudson Cradle’s more recent boarder babies (n=98) in Table C.

### Table C. Benchmark Timeframes of Hudson Cradle and Comparison Group Boarder Babies

<table>
<thead>
<tr>
<th>Timeframe</th>
<th>Cases Admitted to Hudson Cradle after 1/1/94 (n = 98)</th>
<th>Cases Admitted to Hudson Cradle before 12/31/93 (n = 44)</th>
<th>Comparison Cases Admitted to Hospital in 1991 (n = 16)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Days Stayed in Hospital</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>44.0</td>
<td>47.4</td>
<td>46.9</td>
</tr>
<tr>
<td>Standard Deviation</td>
<td>24.9</td>
<td>44.4</td>
<td>31.3</td>
</tr>
<tr>
<td>Hospital Days Medically Cleared</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>20.4</td>
<td>27.1</td>
<td>29.1</td>
</tr>
<tr>
<td>Standard Deviation</td>
<td>15.7</td>
<td>33.4</td>
<td>25.9</td>
</tr>
<tr>
<td>% of Hospital Stay Medically Cleared</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>50.9</td>
<td>58.5</td>
<td>63.8</td>
</tr>
<tr>
<td>Standard Deviation</td>
<td>27.2</td>
<td>26.7</td>
<td>24.8</td>
</tr>
<tr>
<td>Age (in Days) at Hospital Discharge</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>63.5</td>
<td>88.2</td>
<td>76.5</td>
</tr>
<tr>
<td>Standard Deviation</td>
<td>71.6</td>
<td>114.2</td>
<td>110.4</td>
</tr>
<tr>
<td>Days from Hospital Discharge to DYFS Case Closing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>423.2*</td>
<td>791.1*</td>
<td>883.5</td>
</tr>
<tr>
<td>Standard Deviation</td>
<td>289.3</td>
<td>457.9</td>
<td>586.0</td>
</tr>
</tbody>
</table>

\* p < .01
Treatment and comparison group cases have fairly similar benchmark timeframes; there is no statistically significant difference between the two groups on any of the measures in Table C. However, the average age at hospital discharge of the boarder babies more recently admitted to Hudson Cradle, as well as the mean number of days that they stayed in the hospital and the mean number of these days that were medically cleared, all seem quite a bit lower than the comparable figures for the treatment and comparison groups; but none of the differences is statistically significant, at p < .05. The average duration of the more recent group's closed DYFS cases — from the time a boarder baby left the hospital until DYFS later closed his or her case — was only about half as long as those of the treatment and comparison groups; and this difference is, in fact, statistically significant, at p < .01.

To confirm that the treatment and comparison groups are indeed comparable, we tested for significant differences between them on a wide variety of demographic, background and health-related variables. There were no statistically significant differences between comparison and treatment cases on any of the following items:

**Children’s Characteristics** - gender; ethnicity; birth weight; gestational age; Apgar scores at 1 and 5 minutes after birth; positive toxicity to cocaine, heroin, methadone, or other controlled substance; presence of neonatal complications; length of neonatal hospital stay; exposure to a sexually transmitted disease; whether discharged from hospital to birth family member after birth.

**Parents’ Characteristics** - whether mother received any prenatal care; number of older children; number of children living with her and in foster care; types of prior child abuse and neglect alleged against her; number of prior placements of her children; mother’s age; mother’s education; father’s age; father’s education; mother’s prenatal cocaine, heroin, methadone, alcohol, and other drug abuse; mother’s homelessness; whether mother is developmentally disabled or physically handicapped; mother’s prior psychiatric involvement; mother’s receipt of welfare; mother’s employment status

**DYFS Case Characteristics** - referral source for child; reason for child’s referral; voluntary or court-ordered placement

We discovered statistically significant differences between the two groups on only three dimensions among all the variables we examined. Half the treatment group boarder babies, as compared to only a fifth of the comparison group, reportedly experienced drug withdrawal symptoms — e.g., jitteriness, extreme irritability, tremors. However, the proportion of boarder babies in each group who actually had to be treated medically for withdrawal was almost the same. A third of the treatment group children’s mothers had a serious medical condition — mostly AIDS — as compared to just one in 16 in the comparison group; and a significantly higher share of the former’s babies were born HIV-seropositive. And, finally, the mothers of comparison group children were much more likely than those in the treatment group (44% to 11%) to have been previously accused of excess corporal punishment of a child — perhaps a

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5 The Pearson chi-square statistic was used to test for differences between treatment and comparison cases when nominal data, like prenatal drug exposure or prior DYFS history, were examined. A t-test of independent-samples group means was used when interval or ratio-scale data, like mother’s age or number of days in foster care, were tested. In all cases, a two-tailed test of significance at p < .05 was adopted.
statistical fluke since the prior rates of all other types of alleged child abuse and neglect were similar for the two groups.

Because — apart from these three areas — both the children and parents in the two groups are closely matched, any differences we find in rates of contact, service provision or outcomes should be the related to Hudson Cradle’s involvement with cases in the treatment but not the comparison group. We examined each case’s contact and service provision rates for four half-year periods (i.e., two years), starting with the month during which the child was discharged from the hospital. We calculated, for each of these periods, the following measures (all expressed in terms of a monthly average):

- caseworker contacts (by either DYFS or Hudson Cradle staff) with birth parents and other relatives, in the home or field, in the office, and by telephone;
- days the child was in foster care (defined as any placement arrangement; including the Hudson Cradle residence), living with a birth parent or other family member, and re-hospitalized;
- times the birth mother and father visited the child (if the child was not living with a family member during the month); and
- outpatient medical visits.

The results of this analysis are reported in Table D. In the first six months following hospital discharge, Hudson Cradle family members were significantly more likely than those in the comparison group both to have telephone conversations with a caseworker and to attend meetings with a caseworker at his or her offices — a not unexpected result since this was the time during part of which all the Project cases would have had a child living at the residence; and the workers there often tried to arrange face-to-face meetings with parents or relatives when they were visiting. Also in the first six months after leaving the hospital, Hudson Cradle children were significantly more likely to continue visiting doctors and clinics than the comparison group — again a function of where they were staying and the integral connection between the Project and JCMC. This difference persisted over the next six months as well, in large part because of various appointments made on behalf of the children while they were still residing at Hudson Cradle.

On the other hand, Project children were significantly less likely than the comparison group to be reunited with a family member during the first six months after their hospital discharge — in large part because, by definition, they first had to go into the residence for some period. The gap in family reunification rates was statistically significant only during this initial period; over the succeeding year and a half after hospital discharge, the two groups had roughly equal proportions of children spending time in the home of a birth parent or other relative.

During the first six months following hospitalization, the frequency of visiting by birth mothers favored Project children over those in the comparison group; and the difference was large enough to be statistically significant. After that period, the gap in visitation rates gradually narrowed until, at a year or more, the amount of maternal visiting taking place in both
groups was about the same. Levels of visitation by the birth fathers was equally low among
the treatment and comparison group cases, to start with — and then declined even further.

**Table D: Monthly Contact Rates of Treatment and Comparison Group Cases**

<table>
<thead>
<tr>
<th>Average Monthly Number of...</th>
<th>Months from Child's Hospital Discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 - 6</td>
</tr>
<tr>
<td>Caseworker contacts at home or in field</td>
<td></td>
</tr>
<tr>
<td>Treatment Group</td>
<td>0.8</td>
</tr>
<tr>
<td>Comparison Group</td>
<td>0.8</td>
</tr>
<tr>
<td>Caseworker contacts in office</td>
<td>Treatment Group</td>
</tr>
<tr>
<td>Comparison Group</td>
<td>0.3</td>
</tr>
<tr>
<td>Caseworker contacts by telephone</td>
<td>Treatment Group</td>
</tr>
<tr>
<td></td>
<td>Comparison Group</td>
</tr>
<tr>
<td>Days the child was living in foster care</td>
<td>Treatment Group</td>
</tr>
<tr>
<td></td>
<td>Comparison Group</td>
</tr>
<tr>
<td>Days the child was living with birth family</td>
<td>Treatment Group</td>
</tr>
<tr>
<td></td>
<td>Comparison Group</td>
</tr>
<tr>
<td>Days the child was re-hospitalized</td>
<td>Treatment Group</td>
</tr>
<tr>
<td></td>
<td>Comparison Group</td>
</tr>
<tr>
<td>Times the birth mother visited the child</td>
<td>Treatment Group</td>
</tr>
<tr>
<td></td>
<td>Comparison Group</td>
</tr>
<tr>
<td>Times the birth father visited the child</td>
<td>Treatment Group</td>
</tr>
<tr>
<td></td>
<td>Comparison Group</td>
</tr>
<tr>
<td>Outpatient doctor visits by the child</td>
<td>Treatment Group</td>
</tr>
<tr>
<td></td>
<td>Comparison Group</td>
</tr>
</tbody>
</table>

° p<.05   ° p<.01

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Service provision was defined simply as a dichotomous variable: whether or not anyone in the case ever received assistance from DYFS or Project staff in securing a specified service at least once during a given period. The actual measure used was the percent of active cases receiving such assistance in each six-month period. Table E shows this statistic, for the treatment and comparison groups, for each of the 11 services most frequently offered during the Project's early years — other than medical services (which were examined in another context in the preceding table). During the first six months following hospital discharge, the only services which Project children were significantly more likely to have been offered were those related to developmental evaluation and intervention — again, a function of Hudson Cradle's program design and its relationship with providers through JCMC. While Project cases also appear much more likely to have received an emergency assistance check — usually for clothing upon entering and leaving Hudson Cradle — during this period, the difference between the two groups is not statistically significant. In fact, over the succeeding three half-year periods, only one other service was offered to case members in either group at a significantly higher rate (i.e., home health aides for Project children).

Finally, we looked at three outcome measures for the children. The first turned on whether a child had continued to live in the same area as its birth family, which we defined through a surrogate measure: whether or not the child's case was ever supervised by a DYFS district office in a county other than that where the case had originated. The second centered on permanency, which we defined by the child's living arrangements: whether, most recently, the child was living with a birth parent, other family member, pre-adoptive or adoptive family, or a foster family. The third related to whether the child required DYFS supervision throughout the entire period after he or she left the hospital — i.e., had DYFS ever closed his or her case?

The results of the first analysis show that approximately similar proportions of Project children (27%) and comparison group children (19%) had lived out of their local area for some period of time; so admission to Hudson Cradle had not produced significantly greater opportunities for keeping children close to their families. The tendency to transfer children out of the local area is probably more related to their medical status and need for a special foster home than to any Project involvement, per se. The results of the second analysis show that treatment and comparison group children had fairly similar living arrangement profiles as of July-August 1997. Thus, 18 percent of Project children and 25 percent of the comparison group were last living with a birth parent; 27 percent and 19 percent, respectively, with another relative; and half of each group, with an adoptive or pre-adoptive family. In the remaining three cases, children were either in a foster home or had died. So, being served by Hudson Cradle did not increase a family's chances of being reunited. The results of the third analysis show that the DYFS cases of 80 percent of the Project children and 94 percent of the comparison group children had been closed — at least once — by July-August 1997. Given the somewhat longer timeframes available to resolve issues for the comparison group children, these closing rates would seem to be roughly equivalent.

In sum, the children who had been at Hudson Cradle experienced case histories, in most respects, similar to those who had not stayed at the facility. Whatever differences were found in contact and visitation rates, services offered and outcomes, generally occurred relatively soon after the children were released from the hospital — i.e., they were a direct function of the first group's residency in Hudson Cradle — and did not persist particularly long afterwards in their effects.
**Table E. Service Provision Rates for Treatment and Comparison Group Cases**

<table>
<thead>
<tr>
<th>Percent of Cases Ever Receiving the Service during Period...</th>
<th>Months from Child's Hospital Discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 - 6</td>
</tr>
<tr>
<td>Emergency assistance check</td>
<td></td>
</tr>
<tr>
<td>Treatment Group</td>
<td>82</td>
</tr>
<tr>
<td>Comparison Group</td>
<td>62</td>
</tr>
<tr>
<td>Help getting welfare, Medicaid, food stamps</td>
<td></td>
</tr>
<tr>
<td>Treatment Group</td>
<td>14</td>
</tr>
<tr>
<td>Comparison Group</td>
<td>19</td>
</tr>
<tr>
<td>Visiting home aide</td>
<td></td>
</tr>
<tr>
<td>Treatment Group</td>
<td>30</td>
</tr>
<tr>
<td>Comparison Group</td>
<td>19</td>
</tr>
<tr>
<td>Psychological evaluation of parent</td>
<td></td>
</tr>
<tr>
<td>Treatment Group</td>
<td>20</td>
</tr>
<tr>
<td>Comparison Group</td>
<td>25</td>
</tr>
<tr>
<td>Psychotherapy for parent</td>
<td></td>
</tr>
<tr>
<td>Treatment Group</td>
<td>21</td>
</tr>
<tr>
<td>Comparison Group</td>
<td>19</td>
</tr>
<tr>
<td>Help getting into a support group</td>
<td></td>
</tr>
<tr>
<td>Treatment Group</td>
<td>18</td>
</tr>
<tr>
<td>Comparison Group</td>
<td>12</td>
</tr>
<tr>
<td>Help getting into drug abuse treatment</td>
<td></td>
</tr>
<tr>
<td>Treatment Group</td>
<td>41</td>
</tr>
<tr>
<td>Comparison Group</td>
<td>31</td>
</tr>
<tr>
<td>Parenting skills training</td>
<td></td>
</tr>
<tr>
<td>Treatment Group</td>
<td>16</td>
</tr>
<tr>
<td>Comparison Group</td>
<td>12</td>
</tr>
<tr>
<td>Developmental evaluation of the child</td>
<td></td>
</tr>
<tr>
<td>Treatment Group</td>
<td>96°</td>
</tr>
<tr>
<td>Comparison Group</td>
<td>12°</td>
</tr>
<tr>
<td>Early intervention services for the child</td>
<td></td>
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<tr>
<td>Treatment Group</td>
<td>77°</td>
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<tr>
<td>Comparison Group</td>
<td>0°</td>
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<tr>
<td>Transportation assistance</td>
<td></td>
</tr>
<tr>
<td>Treatment Group</td>
<td>73</td>
</tr>
<tr>
<td>Comparison Group</td>
<td>56</td>
</tr>
</tbody>
</table>

* p < .05  
* * p < .01
D. CONCLUSIONS

Even disregarding the problems stemming from Hudson Cradle's delayed start-up, the Project ended on somewhat of a mixed note. On the positive side, significant progress was made — once the new coordinator assumed leadership in July 1992 — in the quality of the residential program, in its focus on each child's early development, as well as in a number of administrative and organizational areas. On the negative side, major drawbacks were a persistent inability to keep most of Hudson Cradle's beds occupied — until the Project began accepting more temporary emergency placements in mid-1995 — as well as the staff's inability to engage many of the parents and other relatives of the infants while they were staying at the facility. Perhaps most telling is the finding that the children who stayed at Hudson Cradle experienced DYFS case histories that were similar, in most respects, to those of children who had not been at the facility. Most of the differences found between these two groups — whether in contact and visitation rates, service provision or outcomes — generally occurred soon after the children had been released from the hospital, while some were residing in Hudson Cradle and others were not. And, overwhelmingly, whatever differences we saw during that period seem to have narrowed — if not disappeared altogether — with the passage of time.

1. Accomplishments

The Project's most noteworthy accomplishments were:

Staffing. A viable staffing pattern — encompassing the Project's medical, developmental, social service and caregiving functions — has evolved. Highly qualified and experienced individuals, who know both their field and the community, were recruited, trained and placed in position. When there was staff turnover — even at the higher levels — the Medical Center used its own considerable resources and was able to allocate personnel to carry out intended functions until vacancies were filled. The Project's line staff, most notably the infant caregivers, proved to be committed, resourceful and effective.

Facilities and Procedures. The Project's residential facility was brought up to operational status relatively quickly — once construction was completed in early 1993 — and its functioning improved dramatically, over time, as lessons were learned and incorporated into standardized procedures. Project administrators have been open to constructive criticism and suggestions. Significant progress was noted regarding the content of the Project's in-service training and the quality of its recordkeeping efforts. Everyone involved is demonstrably proud of their facility, and its program still holds out great promise for Hudson County.

Boarder Babies. All told, the Project provided residential care, together with other services, to 169 hospital boarder babies and other infants. These children, some of whom were medically quite fragile, typically resided for one to three months in Project facilities. Virtually all were developmentally screened and received early intervention services, along with medical treatment and daily care, including food, clothing and shelter. Those birth parents who were served received mainly counseling as well as referrals for parenting skills training and other assistance from Hudson Cradle staff and
for services related to substance abuse treatment from their DYFS caseworkers. Just over a fourth of the children were returned to a parent or other relative at the time they were discharged from Hudson Cradle. Two had to be re-hospitalized, and the remaining 71 percent went into foster homes. But, by July-August 1997, almost half the Project children had been reunited with family members; and another fourth either had been adopted or were freed for adoption and living in a pre-adoptive home.

These accomplishments are not insignificant, given the various logistical and procedural obstacles with which the Project had to contend — especially early on, when facility construction was involved. (In fact, one almost could have predicted the Project’s slow start-up, once the need for reconstruction at the selected site had become evident.)

2. Differing Priorities

A factor hindering Project implementation related to the differing priorities of its immediate sponsors: Hudson Cradle (the "creator" of the concept), DYFS (the "grantee"), and the Medical Center (a "subcontractor"). These differences were reflected in the timing of Project implementation and, later on, in the choices around who would be served and how they should be helped.

In a sense, it is ironic that DYFS, which might have been seen by the others as somewhat of a late arrival to the "party," controlled the purse strings for most of their joint endeavor. Hudson Cradle — as its name implies — was initially organized as a community-based consortium to respond to a serious local problem: Hudson County's boarder babies. Jersey City Medical Center was instrumental not only in organizing Hudson Cradle, as a technique for highlighting this issue, but also in winning over local business and political leaders in support of the concept. When Hudson Cradle proposed developing an alternative to having babies languish in the hospital after they were medically ready for discharge, DYFS saw an opportunity to raise money for this effort, by responding to a federal request for proposals pursuant to the Abandoned Infants Assistance Act; and it was subsequently chosen to receive a grant.

Because DYFS was the official grantee, it bore the ultimate responsibility for adhering to the grant's conditions. One of DYFS's primary considerations was to meet federal expectations around Project timeframes — i.e., to start providing services as soon as possible — given the fact that the agency took over a half-year to formally select its subcontractor. JCMC, for its own part, was more interested in assembling the Project's staff and completing all the necessary logistical and organizational arrangements prior to accepting the first clients and providing services. Because the Medical Center was its subcontractor, DYFS felt compelled to ensure that JCMC also conformed to what it perceived to be federal timeframes; hence, the agency pushed the Medical Center into what its senior staff considered to be a "premature" Project opening.

This, in turn, increased the pressure on JCMC to get a program coordinator on board, as soon as possible, and has been offered as one reason why the Medical Center initially settled on someone other than a registered nurse for that position. With operations prematurely engaged in, from a temporary facility, and without all the appropriate staff on board, the new
program coordinator started out at a disadvantage and apparently never recovered. With his involvement almost totally focused on playing catch-up, it is not surprising that important facets of the program, like recordkeeping and a staff training program, never received adequate attention.

3. Conflicting Program Models

The early delays and their effects notwithstanding, the main issue that confronted the Project from the outset was its being caught in the middle, between the conflicting agendas of its sponsors. And, the ongoing contention between DYFS and JCMC was not a simple matter of personalities but rather a reflection of quite disparate concepts about service delivery which the two organizations had developed, over many years, in response both to their own target populations as well as to the legal and administrative mandates under which each must operate.

Based on their respective responsibilities and historical expertise, DYFS and JCMC differed in the way they conceived of the Project. Each organization approached the Project with its own service delivery model in mind. Basically, the social services agency viewed the Project as a child welfare vehicle, while the hospital adopted a medical paradigm. These models assume different constraints, promote distinct administrative styles, and involve dissimilar expectations.

In the evaluator's view, both JCMC and the Project tended to treat the infant as their principal client; and the infant's condition often required that medical and developmental case management as well as the actual dispensing of medication be the staff's principal concerns. So, for example, all caregiver staff were initially provided in-service training in monitoring children's physical signs (e.g., temperature and weight) but not in evaluating their developmental progress or the quality of parent-child interaction. In a similar vein, initially caregivers were instructed to cover whichever child needed attention — much as if they were still on one of the Medical Center's wards — with no thought given to the benefits of assigning primary responsibility for each child to a specific individual.

Despite the Project's ostensible goal of reducing unnecessary hospitalization, one could sense a perhaps unconscious and unintended effort, on JCMC's part, to retain a pervasive, hospital-like control over the children (i.e., the "patients") and their families. This feeling was reinforced when the impasse, created by the State Board of Nursing, over administering medication was temporarily resolved by keeping the more medically at-risk children at the hospital until their needs could be adequately met at the interim facility. In a way, the whole flap over administering medication reflected this duality. What message did the Project send to the birth parents — whom it intended to train and empower to care for their own children — when caregivers employed and trained by the hospital were not empowered to administer Tylenol? Also, what message was being relayed to the caregivers themselves, and how were they being represented as models for the parents to emulate? Does giving Tylenol always require that a nurse be present — even if the infant were at the birth parent's or a foster parent's home?
Because the original proposal was written by DYFS, the Project was saddled with the objective of effectuating a 50-percent reunification rate, which — while certainly laudable — seems, in retrospect, to have been overly optimistic, especially since the Project had little, if any, ongoing contact with children once they were discharged — typically — to a foster family. Essentially, despite the written goal, Project staff continued to follow a service strategy common to hospital settings: children received services on-site, either when visiting the clinic or after being admitted as an inpatient. Furthermore, since the decisions determining the timing of each child's discharge as well as the type of placement selected were solely within DYFS's purview, the "credit" for any reunification which took place after discharge accrued — rightfully — to DYFS rather than to the Project. Of course, with credit also comes blame; and, on several occasions, Project administrators criticized DYFS for peremptorily removing a child from the facility in order to effectuate a foster care placement or some other aspect of its own service plan, without allowing residential staff enough time either to notify and counsel the birth parents about this development or to meet with the new foster parents so they could be informed about the special needs of the child who was to be placed in their home.

These lapses notwithstanding, in DYFS's view, the child's birth parents must be considered the Project's clients just as much as — if not, at times, even more than — the children; but their needs are legally defined for DYFS as centering on issues related to placement and permanency. In this light, it is not surprising that DYFS administrators reacted forcefully when they learned, early on, that significant observations by Project caregivers of parental behavior and parent-child interaction — observations that could conceivably bear on the possibility of reunification — were not being communicated routinely to the responsible DYFS case manager. On the other hand, DYFS caseworkers themselves were faulted by Hudson Cradle staff for not providing a proper orientation to birth parents about the Project, once the decision to transfer their child into the Project's care had been made. The information given to these parents tended to deal with their need to enroll in a substance abuse treatment program, to find a job, and/or to secure adequate housing — typical issues for most DYFS cases, that bear directly on the possibility of reunification — rather than explaining the Project's unique services and goals. So, birth parents would often come to — or, perhaps, never even visit — the facility with the idea that their child's residence there was simply the "system" responding to their own substance abuse or hopelessness and with no clear idea of what was expected of them, in the short run, or of how they and their child might benefit from the experience.

Further, JCMC staff stated that, even given the decrease in the hospital's boarder baby census, most of the time there were enough infants known to them to fill up all the Project's beds. Nevertheless, because of how DYFS was compelled to define Project eligibility, before JCMC can transfer any child to the Project's care, a decision regarding the placement of that child first had to be made by DYFS on child protection grounds. DYFS staff contended that they face severe legal and case-practice constraints which determine when they can decide that the agency should assume responsibility for a child and, by this means, effectuate the transfer of that child into Project facilities. Thus, the agency was unable to expedite the referral to the Project of infants who were medically cleared for discharge, if their parents — or another family member whom they had designated — were still considered potential caregivers.

Other complications arose from many of the children being classified as medically fragile and thereby requiring placement in a specially-trained SHSP foster home. Since there were not
enough of these providers available locally, a sizable minority of the children ended up out of the area. This surely had an effect by distancing the child — both physically and emotionally — from its birth parents. Not only the parent-child but also the parent-caseworker relationship suffered; and this was reflected in lower rates of service provision as well as child visitation. In addition, with the SHSP designation came the increased likelihood of yet one more transfer for the child — into a regular foster home once his or her health had been stabilized. It would be difficult to argue that, even with the best of care, a model deliberately incorporating four moves during a child's earliest and most formative years — from a hospital to a residential facility, and then to two different foster homes — is in the child's best interests.

Given the Project's slow start-up and empty beds, pressure was exerted on numerous occasions to rethink whom the Project ought to be serving. As noted, DYFS field staff originally had hoped to utilize Project beds, whenever available, for their own emergency placements. DYFS administrators, while empathizing with their staff, recognized Hudson Cradle's reluctance to revise the scope of the Project; so, at the time, they went along with the idea that boarder babies from other counties ought to be admitted to the facility when there was a free bed. An attempt to implement this policy did, however, create its own set of problems since, once the wider net was cast, both the physical distance and lack of familiarity between principals made coordination difficult. A great deal of time and effort went into the early referrals from other counties; and, in the end, a number fell through. Subsequently, it was agreed that Hudson Cradle would accept emergency placements and open up a bed or two for brief respite care stays.

The initial disagreement over opening up unoccupied beds for emergency placements also reflected the divergent priorities of Project and DYFS staff. In the competition for ever-scarcer resources, during a time of increasing family vulnerability and decreasing budgetary allocations, Hudson County DYFS staff, in effect, were expressing the hope that the Project's resources, as much as possible, would be reserved for their own cases; whereas Project staff were just as intent on adhering to their own interpretation of the "original plan," and reserving their services for boarder babies, even if this course of action resulted in a temporary underutilization of the Project's physical facilities.

An issue perhaps equally significant to that of filling beds related to parent-child visitation, which — on the whole — had not been nearly so frequent as was originally planned. Few parents visited their child at the facility three or more days a week, for three or four hours at a time. If, given a mother's drug abuse and other problems, this reflected her meager commitment to regaining the child, then the lack of visiting was actually a manifestation of her readiness to surrender the baby or, at least, of her desire to avoid developing bonds with, and feelings of responsibility for, the child. If, on the other hand, this was a result of an insufficient orientation or of inadequate motivation, then different service strategies might have achieved better results. Even when the level of a parent's visiting was increased — through such techniques as providing for transportation and related expenses, offering services that he or she wanted, and broadening visiting hours — visitation, *per se*, while clearly an indicator of the potential for reunification, was not always be the most accurate one. Rather, the degree to which a parent could be involved in, and demonstrated a sense of responsibility for, her own child's everyday care, often seemed to be a more telling predictor.
4. Conclusions

It is our conclusion that Hudson Cradle held out but never quite fulfilled its great promise; its mixed success resulted, in large part, from organizational relationships and service strategies developed six years ago. Nevertheless, it must be borne in mind that the Project had a greater impact than that which was simply related to the children and families it directly assisted.

Clearly, it is the hope of all involved that Hudson’s Cradle’s work with these cases will ultimately result in decreased child welfare costs when family members are reunited; lower social welfare expenditures when parents become more self-supporting; fewer medical care costs after chronic and/or congenital health conditions are resolved; and reduced special education expenditures once children’s developmental delays are evaluated and early intervention services are provided in a timely manner.

In the near term, however, the Project has already had a sizable impact — one that extends well beyond the direct assistance provided to its clients. Hudson Cradle’s consistent emphasis on identifying potential boarder babies early on and expediting their release from the hospital to a family member or into foster care has helped influence state, local and hospital policies and procedures — speeding up the decision-making process around, and the service delivery system’s response to, each medically-cleared infant being held in a hospital bed awaiting discharge to an appropriate family member or placement resource. The cumulative effect of these changes may end up being of greater consequence to the area’s boarder babies than the direct provision of Project services to targeted clients.
October 30, 1997

Ms. Patricia Campiglia
Children’s Bureau
US Dept of Health and Human Services
PO Box 1182
Washington, DC 20013

Re: Hudson Cradle Final Evaluation Report

Dear Pat:

Per your request during our telephone conversation this morning, please find enclosed a copy of my final evaluation report for the NJ Division of Youth and Family Services’ AIA-funded Hudson Cradle Project. The official submission of the report should come soon from DYFS.

If you have any questions or need any further information, please give me a call.

Sincerely,

[Signature]