EXECUTIVE SUMMARY

In 1995, The New Jersey Division of Youth and Family Services (DYFS), the State child welfare and protection agency increasingly responded to referrals of very young children who were abused, neglected or abandoned by parents with alcohol or drug problems. The escalating use of alcohol and drugs among women of child bearing age resulted in increasing numbers of infants born drug exposed, HIV infected, and/or medically fragile. One of the most devastating outcomes of these trends was the number of infants who remained in hospitals beyond medical necessity, because their families were unable or unwilling to care for them. These infants became referred to as “boarder babies.”

In response to this problem DYFS established the Boarder Baby Project team under the direction of the DYFS Office of Special Program Initiatives. Comprised of child welfare, health care, foster parent and child advocate representatives, the project team was convened to study the problem of children who remain in hospitals beyond medical necessity because their families were unable or unwilling to care for them. Based on this study the project team was charged with developing recommendations intended to reduce the number of boarder children. The team reviewed and analyzed available information relative to the scope of the boarder child problem, the characteristics of boarder children and the factors contributing to children remaining in hospitals beyond medical necessity.

A direct outgrowth of the analysis by the Project Team was the development of the proposal for the Newark New Start Project. In 1996, the proposal was submitted for funding under the federal Abandoned Infants Assistance (AIA) program. The project was funded October 1, 1996 and subsequently refunded each year for a four year period that ended September 29, 2000.

The Newark New Start Project was designed to demonstrate a model of interagency collaboration which incorporates peer services, home-based services, and coordinated medical and social case management to facilitate the timely discharge of infants from hospitals, to reduce medically unnecessary hospital stays, and to expedite discharges to the most family-like setting without the necessity of extended congregate care placement.

The project was located in the city of Newark, NJ (Essex County) because boarder baby incidence data and other measures of child and family well-being pointed to the overwhelming nature of the problem there. A 1996 DYFS report, indicated that Essex County had the fourth highest incidence of boarder babies in the nation and the highest number of boarder babies in New Jersey. The Association for Children of New Jersey ranked Essex County last out of New Jersey’s 21 counties in the composite areas of low birth rate, lack of prenatal care, infant mortality, child AFDC rate, and other factors.
Alarming statistics additionally focused the Division's attention on the city of Newark. The majority (56%) of infants under DYFS supervision in the Metropolitan Region, discharged from hospitals over a two year period, lived in Newark. Other serious health and social problems were endemic to Newark and contributed to its selection for the project. In 1993, Newark's infant mortality rate was 16.2% as compared to the state average rate of 8.3%. Poor pregnancy outcomes, inadequate prenatal care, high adolescent pregnancy rates and lack of age appropriate childhood immunization contributed to this high rate of infant mortality. A report issued by DYFS in 1995 indicated that in over 34% of the substantiated abuse or neglect cases, a caregiver was documented as having a substance problem. In Newark, the percentage rose to 50% of the caregivers. In that same year (1995) 566 babies were born drug-exposed due to prenatal substance abuse and with a substantiated report of abuse or neglect. Newark babies accounted for 44% of these infants and the rest of Essex County accounted for another 12% of them. The city of Newark, with the largest population in the state, had 26% of its residents living below the poverty level as compared to only 7.5% in the state. At 22.2% Newark had the highest percentage of households which received public assistance.

Focused on providing services in the city of Newark, the Newark New Start Project established itself as a DYFS-led consortium of hospitals and community agencies in 1996. Consistent with the design requirements for Abandoned Infants Assistance programs, the project defined its goals:

- To facilitate the timely discharge of infants from the hospital;
- To reduce medically unnecessary hospital stays;
- To expedite hospital discharges to the most family-like setting without the necessity of extended congregate care.

The project was designed as a model of interagency collaboration which incorporated coordinated medical and social case management to facilitate the timely discharge of infants from hospitals. It combined prenatal and postpartum intervention strategies including drug abuse identification and treatment, as well as home assessments of prospective caretakers. Through its four (4) years of operation, the project has had as its immediate goal the reduction of infant abandonment rates in Essex County, where newborns spent an average of 45.7 days in the hospital after they were medically cleared. By the end of the third year the project affected a 77% decline in the average stay to 10 days. This is Newark New Start's most impressive achievement.

Other results are noteworthy as well. While serving over 1900 infants and their families over the first three years, the project has been successful in coalescing the health and social services community in Essex County into a coordinated network aimed at serving these at-risk infants and their families. The development of a collaborative system has resulted in an increase in the availability of services and has additionally improved the efficiency of the referral process for these families.
Since the inception of the Newark New Start Project, specially trained and designated DYFS casework staff, as well as the Project Manager and administrative staff of the Metropolitan Regional Office, have been assigned to visit the hospital on a regular basis, and conference potential cases. They are also on-site to receive referrals from hospital social workers. (These DYFS case managers are assigned to the project at no cost to the grant budget.)

These designated case managers provide expedited and intensive child welfare services to at-risk newborns. They work in consultation with the hospital social workers to determine whether a child is at risk and needs referral to DYFS, or can be safely diverted to New Community Corporation for family assessment and intervention.

These case managers provide an immediate response to the hospital, meet with the mother at the hospital, and are often accompanied by the Certified Alcohol and Drug Counselor (CADC) attached to their unit. This on-site presence allows for the immediate access to the mother or family members who may visit, and therefore the ability to obtain vital relative resource information, and early drug assessment and treatment intervention.

The DYFS worker assesses the situation in relation to the mother’s ability to care for the child, and based on that assessment, develops a child welfare plan for either discharge to the mother, discharge to relatives, or discharge to foster care. Additionally, the specialized worker has daily conferencing with hospital and social work staff, daily visits to assigned hospitals, contacts with each nursery, and is available to sign any consent forms needed. Their presence in the hospitals expedites the development of the child’s case plan.

Prior to the implementation of the Newark New Start Project, the need to assess relatives as alternative caregivers constituted a substantial barrier to the discharge of the child from the hospital. The case managers at the DYFS Essex County District Offices were required to prioritize investigations of serious abuse or neglect in the community and did not have the capacity to complete these relative assessments in a timely manner.

Noting that two-thirds of boarder babies were ultimately discharged to relatives or the birth parents, the project planners identified rapid assessments of relatives and birth parents as a major strategy to facilitate discharge for these children. This resulted in contracting with the Newark Family Resource Network (NFRN) to perform these assessments.

Women assessed by DYFS as unable to care for their children are asked to identify an alternative caretaker. Utilizing the services of Newark Family Resource Network, these potential caretakers are assessed within 24 hours to determine their willingness and appropriateness to care for the infant. If the initial assessment is positive, the DYFS caseworker visits the caretaker, confirms the appropriateness of the assessment, and finalizes the case plan, including the provision of needed supports and services.

To date, NFRN has received 1,038 referrals, which has resulted in the completion of 1,214 assessments of potential caretakers.
Successes notwithstanding, they were only achieved after the project confronted a number of problems.

The initial problem of a fragmented health and social service network involved with the border baby population, was a major obstacle to the delivery of services. The project developed protocols, and established regular meetings with participating agencies. This has resulted in creating a strong collaboration of community agencies vested in working in the best interests of border babies and their families.

Efforts to intervene early with at-risk pregnant women were problematic because they typically did not seek prenatal care, and as a result could not be identified until in labor at a hospital emergency room. The project reached out to the largest hospital in Newark to identify these women and to provide outreach follow up services.

Some children, despite project efforts, remained in hospital boarding status for lack of a relative caregiver or foster home. The DYFS has implemented a statewide initiative aimed at improving and increasing the network of foster homes. The project is looking towards the greater availability of homes as a result of this effort.

Some children who are placed in foster care cannot be returned to their parents or relatives. The project has worked on behalf of these children by expediting permanency planning efforts consistent with DYFS' implementation of the Adoption and Safe Families Act (ASFA) as well as its own reform initiatives in this area.

Those women who have given birth to more than one border baby, who are transient, have long histories of substance abuse, and repeated involvement with DYFS have been the most difficult to serve. Early identification efforts are being developed to locate these women in the DYFS caseloads and the caseloads of their community-based programs.

The evaluation of the Newark New Start project over the first three years of operation, that besides yielding data, has resulted in implications for case practice. The project has served over 1900 children and their families in Essex County. Among AI/A grantees, the project was a leader in the total number of clients served over the period. Several statistics demonstrate the enormity of the problem the project has confronted and the difficulties faced by members of the population served. Over 96% of the mothers were unemployed, over 92% had no insurance, and over 95% were unmarried. Even so, 21.8% of these women were receiving benefits (AFDC, WIC, Medicaid, etc.) at the time of their child's birth. Approximately 54% had a previous history of involvement with DYFS. Based on multiple sources of data, it was estimated that at least 77.1% were abusing drugs at the time of birth although only 28.4% of drug-abusing mothers were receiving substance abuse services at the time and 24.9% had never received services. Infants have demonstrated of medical problems, including low birth weight (45%) neurological problems (9.3%), and HIV (3.8%).
Significant to the past success of Newark New Start has been the willingness of DYFS administrative staff to modify case practice and to institute organizational changes in order to achieve better outcomes for children. Examples of this have included the development of a specialized group of workers who serve boarder babies only. The commitment will continue and case practice reviews will take place in the following areas where:

- Repeated opening and closing of cases that address only the current infant at-risk and that result in service disruption. DYFS will keep boarder baby cases open, even if a child is placed with a relative, in order to continue to work with the mother, engage her in project services and decrease the likelihood of her giving birth to another boarder baby.

- Limited attention is given to family planning. Community resources will be identified and DYFS staff will be trained to make appropriate referrals. This approach will provide options for the mother before becoming pregnant and as a result have an impact on the incidence of boarder children and the risk of transmission of HIV from mother to child.

- There is a need for intensive outreach services. The Newark New Start Project mobilized the Division's casework resources and provided the stimulus for case practice changes that have resulted in immediate DYFS response to hospitals. This approach substantially improved DYFS access to women who just delivered an at-risk infant. Unfortunately, these women tend to be transient, and difficult to service. This is particularly true for child welfare caseworkers who have multiple responsibilities. Outreach workers who have been assigned to work with these women have been invaluable in locating women "lost" to traditional social service programs, and have been able to bring them back for services.

- There is a need for continued collaboration. The Newark New Start Project provided the framework for agencies to come together to address a critical community problem. Although DYFS took the lead through the grant, the Newark New Start Project was also successful in understanding that this was more than a child welfare problem. Rather it had numerous causes, including access to health care, substance abuse treatment, poverty and housing, to name a few. Successful efforts to ultimately resolve this problem will require greater participation from public and private agencies that have responsibilities in these areas.
I. STATEMENT OF THE ISSUE/PROBLEM

The New Jersey Division of Youth and Family Services (DYFS) is New Jersey’s public child welfare and child protection agency. In 1995, DYFS increasingly responded to referrals of very young children who were abused, neglected or abandoned by parents with alcohol or drug problems. The escalating use of alcohol and drugs among women of child bearing age resulted in increasing numbers of infants born drug exposed, HIV infected, and/or medically fragile. One of the most devastating outcomes of these trends was the number of infants who remained in hospitals beyond medical necessity because their families were unable or unwilling to care for them.

These infants are often referred to as “boarder babies.” The majority of these infants had been prenatally exposed to alcohol and/or drugs and were at risk of physiological, developmental, and emotional problems that have short and long-term consequences.

Of additional concern, these infants were not receiving the type of individual attention from a specific caregiver so vital to all newborns. Although the hospitals used volunteers to attempt to address this problem, the infants continued to remain in an institutional setting that was unable to meet vital development needs due to the system’s inability to find a safe, homelike setting for these children.

From 1993 to 1995, an alarming increase in the average number of boarder babies and children were reported in New Jersey (New Jersey Hospital Association, 1995). Essex County had the fourth highest incidence of boarder babies in the nation, (13% of all the boarder children nationwide), and the highest number of boarder babies in New Jersey (Nover 1996). Union County was the second highest. Over three quarters of the boarder children and infants who were tested were found to be drug-exposed; only half of that population were tested for HIV, with between 6% and 8% testing positive. The situation had reached a crisis level.

The Division’s database for the period November, 1994 (when the Division began systematically collecting this information) through June, 1996 indicated that:

- DYFS Regional Offices identified 1,088 “boarder” children;
- Of the 1,036 infants who were ultimately discharged from the hospitals during this period, 786 (76%) were from the Division’s Metropolitan Region (Essex, Union, and Middlesex Counties);
- Of this number, approximately 440 (56%) were from the city of Newark (located in Essex County);
- There had been an average of 54 infants in boarding status monthly statewide, 44 infants in boarding status monthly for the Metropolitan Region, and 35 infants in boarding status monthly from the Newark District Offices.
More importantly, this trend was accelerating. For the period January 1 through June 30, 1996:

- The Division received 299 new referrals of infants in hospital boarding status;
- Of this number 210 (70%) were from the Division's Metropolitan Region which includes Essex, Union, and Middlesex Counties;
- Of this number 134 (44.870) were from the District Offices in Newark. Referrals of infants in hospital boarding status from Essex County represented 80% of the boarder baby referrals from the Metropolitan Region.

From these statistics, DYFS expected approximately 336 referrals of infants in boarding status from Essex County in a 12 month period.

Bearing in mind that 80% of the DYFS Metropolitan Region's children in boarding status were under the supervision of its Essex County District Offices, an analysis of the data concerning the 786 infants from the Metropolitan Region collected over the 19 month period (November 1994-June 1996) indicated that:

- Most children (61%) return to birth families (32%) or to relatives (29%); one quarter are placed in regular foster care; the remaining children (14%) are placed in special foster homes for medically fragile children (8.5%) or other arrangements;
- Children remained in the hospital an average of 35 days, with children returning to biological parents remaining 16 days, to relatives 21 days, and to regular foster care 70 days;
- The most frequently recorded barriers to the movement of the child from the hospital was the assessment of the home or prospective caretaker (45%), no appropriate foster home available (21%), awaiting medical tests (8%), court processing (6%) or other reasons (14%).

The data stated above was crucial to the development of the Newark New Start Project in 1996, in order to address the need of these infants and their families.

Rationale for Selection of Essex County and the City of Newark

With a combined population of 778,206 persons (1990 Census), Essex County represented one of the most urbanized areas in the United States. It is also a major metropolitan area in which children, especially newborns, were experiencing severely deleterious conditions.
Utilizing a composite ranking of measures of child and family well-being (including low birth weight, lack of prenatal care, infant mortality, child AFDC rate and other factors), the Association for Children of New Jersey ranked Essex County last out of New Jersey's 21 counties.

Moreover, Essex accounted for nearly one-quarter of all child abuse and neglect allegations and substantiations in 1994; Newark alone accounted for more than 10% of substantiated allegations of abuse or neglect statewide.

Profile of City of Newark

The city of Newark had the largest population in the state with 275,221 residents. Newark's population was 58% Black; 29% White; 1% Asian and 11% other races. Twenty-six percent (26%) of Newark's population was of Hispanic origin (US Census, 1990.)

In the city of Newark, 26% of all persons lived below the poverty level as compared with only 7.5% in the state. At 22.2% Newark had the highest percentage of households which received public assistance.

According to the Annual Work Plan of the Essex County Healthy Mothers/Healthy Babies (HM/HB) Coalition, poor pregnancy outcomes, inadequate prenatal care, high adolescent pregnancy rates and lack of age appropriate childhood immunizations continued to contribute to the high rates of infant mortality in urban Essex County. Other serious health and social consequences which also contributed to high mortality and morbidity rates included substance abuse, HIV/AIDS and poverty.

In 1993, Newark's infant mortality rate was 16.2% as compared to the state average infant mortality rate of 8.3%. The rate of low birth weight, a leading cause of infant death, for Newark was 13.4%.

Early, risk responsive prenatal care has been shown to be an effective approach to preventing prematurity and low birth weight. The broad objective of prenatal care is to promote the health and well-being of the pregnant women, the fetus, the infant and the family up to 1 year after the birth. In 1994, 81% of New Jersey births were to women who began prenatal care in the first trimester of pregnancy. During this same period births to women who began prenatal care in the first trimester was 64% in Newark, 66% in East Orange, 66% in Orange and 66% in Irvington. Of these Essex County cities, the percentage of births to women receiving no prenatal care was the highest for Newark at 7.79%.

According to a report issued by DYFS in July 1995, Children At Risk, 1993 and 1994, in over 34 percent of the substantiated abuse or neglect cases in 1995, a caregiver was documented as having a substance problem. In Newark, the percentage rose to 50 percent of the caregivers. In New Jersey in 1995, there were 566 babies drug exposed due to prenatal substance abuse where a report of abuse or neglect was substantiated.
Newark babies accounted for 44 percent (249) of these infants and the rest of Essex County accounted for another 12 percent (65) of these infants. Among New Jersey municipalities with the highest number of substance abuse treatment admissions in 1993, Newark ranked the highest with 7,917 admissions (Source ADADS Supplementary Tables: 1993.)

As of May 31, 1996, New Jersey ranked fifth in the number of reported AIDS cases by state of residence with 30,196 reported adult/adolescent cases and 645 reported children cases. According to the New Jersey Department of Health there were 8,031 reported cases of AIDS in Essex County representing 30% of the state total. Women accounted for 25% of all reported AIDS cases in New Jersey compared to 12% nationally. Women accounted for 38% of all reported HIV positive adults in New Jersey. New Jersey ranked fifth in the nation in reported AIDS cases and third in reported pediatric AIDS cases.

II. GOALS AND OBJECTIVES

The goals of the Newark New Start Project were:

- To facilitate the timely discharge of infants from the hospital;
- To reduce medically unnecessary hospital stays;
- To expedite hospital discharges to the most family-like setting without the necessity of extended congregate care.

Objectives

Consistent with the design requirements established for Abandoned Infants Assistance projects, the Newark New Start project had the following objectives:

1. All pregnant women known to DYFS before the birth of their child shall have a plan for the care or placement of the child at birth. These plans may include placement with a relative or foster family.
2. To the extent possible, cases involving pregnant women or children who would otherwise be at risk of abandonment or extended stays in the hospitals not dictated by medical necessity, will be diverted from the protective services system to appropriate community-based agencies by the social services departments of health care providers (New Community Corporation.)
3. Prenatal care and other parenting and supportive services for women known to be at risk due to previous or current supervision by the State child protection (CPS) agency will be arranged and provided by community health agencies through the assistance of agencies employing peer services.
4. All children whether or not they were previously known to DYFS will be placed from the hospital within 3 work days of the date that the child is medically cleared for discharge. This may include placement with the birth family, a relative of the child, a foster home or a pre-adoptive “fost-adopt” home.

5. To prevent the subsequent abandonment of infants or young children who have returned home, the birth family and/or supportive relatives will be provided with an array of services directly relating to the care and well-being of the child and his/her mother. This will include Family Preservation Services, comprehensive prenatal services provided by the Newark Family Resource Network to stabilize the family and to prevent the abandonment of young children who have been returned home to the birth family.

6. When appropriate, substance abuse assessment and referral to treatment will be arranged through the local city-wide substance abuse intake agency (Target Cities) and will be facilitated by the participating agencies, hospitals or a Certified Addictions Counselor dedicated for this purpose to this project.

7. The level of child well-being and child health will be increased for these children through the improved rates of immunization and access to early intervention services that will be made available through the close follow-up by the peer service and health agencies that will be contracted for these services under the project.

8. Expedited permanency for all children will be provided through changes in DYFS administrative procedures and enhanced access to paralegal services required to complete necessary court documents.

III. APPROACH

Interagency Collaboration Model

The Newark New Start Project is a model of interagency collaboration, which combines prenatal and postpartum intervention strategies including drug abuse identification and treatment, as well as home assessments of prospective caretakers. Through a coordinated network of service providers, these approaches work together to facilitate the timely discharge of infants from hospitals, to reduce medically unnecessary stays and to expedite hospital discharges to the most family-like setting, without the necessity of extended congregate care placement.

The project offers a two-track approach for the delivery of services. Whenever possible, lower risk families are diverted from the child protective services system to grant-funded community-based services provided by the New Community Corporation (NCC.) Protocols were developed during the first year of the project to assist hospital social service staff and other agencies in determining which cases may appropriately be referred to NCC, and which children need to be referred to child protective services.
This two-track approach has been proven extremely useful in delivering the appropriate level of intervention to families. Families demonstrating a higher level of risk are referred to DYFS for assessment, referral and if need be, the removal of the child and placement with relatives or foster care. Further, DYFS services were substantially enhanced and reorganized to provide for intensive intervention at the time of the child's birth, and for expedited permanency planning for children who require out of home placement.

Services are readily available to clients, since the point of referral can come from community hospitals, clinics, private doctors, and substance abuse treatment centers, as well as through DYFS. These community-initiated referrals are made through the diversion component operated by the New Community Corporation (NCC.)

Most of the project services are provided in-home, or in the families' own community. As a result, the project does not provide services at a single site, but is managed through the DYFS Metropolitan Regional Office, located downtown Newark. The Metropolitan Regional Office is responsible for all DYFS services in Essex, Union, and Middlesex Counties, thereby facilitating project operations.

Over the four years of the project, the referral network expanded from the city of Newark to include all hospitals, clinics, and community organizations in Essex County.

Project Management

The project management team consists of the Project Manager, and the Assistant Project Manager.

The Project Manager's major job responsibilities are to coordinate project services, ensure clear focus and communication of all collaborative agencies, and identify and respond to service gaps. The Project Manager accomplishes these tasks through:

- Regular consultation/dialogue with each community program individually and as a project group, including the Project Evaluator;
- Maintaining management statistics on infants and their families affected by this project and tracking their progress through the system;
- Overseeing DYFS staff directly associated with the project and monitoring of project components;
- Preparing monthly reports;
- Revising, if necessary, the project and monitoring of project components;
- Attending community-based meetings, as related to the project;
- Development of expansion from the city of Newark to the balance of Essex County;
- Performing all federally required reporting and tasks.

The Assistant Project Manager is responsible for:

- Serving as liaison to the DYFS District Offices to ensure all forms required for foster home placement are completed in a timely manner.
- Serving as liaison to the grant-funded components to ensure good communication, including tracking of referrals and appropriate forwarding of necessary documents to DYFS staff;
- Conferencing cases with various hospital social workers and trouble shooting systemic issues;
- Providing reports and statistics;
- Monitoring all evaluation forms and data base entry;
- Continuing daily project operation in the absence of the Project Manager.

**Role of Hospitals in Identifying Cases for CPS or Diversion**

Prior to the implementation of the Newark New Start Project in 1996, the absence of services required hospital social workers to report all at-risk infants to DYFS. As part of the Newark New Start Project planning process, community agencies in Newark and Essex County worked together to develop protocols for referrals utilizing new services.

Hospitals are a critical control point for the project, as high risk women often fail to seek prenatal care, and do not come to the attention of a health care provider until labor and delivery of the newborn. Initially, services and project efforts were directed to University Hospital (Newark’s largest provider of health care to poor women, and the hospital that housed the largest number of boarder infants) and Newark Beth Israel Medical Center.

Women at risk of giving birth to a boarder baby in Newark and Essex County can now be identified by the health care community and referred to appropriate resources. One of the Newark New Start Project’s most significant successes has been the implementation of this system to identify such women at University Hospital.
Specifically, pregnant women who receive emergency or clinic care, are reviewed by hospital staff to ensure that they are also receiving prenatal care. As appropriate, referrals are made to the hospital OB-GYN clinic and/or to New Community Corporation (NCC) for additional service and support. In addition to receiving referrals from hospitals, referrals also come to NCC through prenatal clinics, private obstetricians, and community agencies that serve pregnant women.

**Role of New Community Corporation**

The grant-funded contract with New Community Corporation has been the primary vehicle for the diversion of families away from the child protective service system. To date, they have served 705 families.

NCC’s primary function is to provide home assessments of birth mothers and other family members who are prospective caretakers for children at risk of becoming boarder babies, and to determine whether the home environment is safe and conducive to the development in the infant. Upon the completion of this assessment, NCC either refers high-risk cases to DYFS for CPS services or accepts the child and family into its program. Referrals to NCC can be made either on a prenatal or postpartum basis.

The NCC program, modeled after Healthy Mothers/Healthy Babies programs deployed across the nation, provides home-based support service by professional and peer project staff to mothers, their newborns and other caregivers.

This combination of services provides the crucial components that divert cases from the child welfare system. The combination of home-based services provides another option to foster placement for children while facilitating timely hospital discharge planning. This has not only resulted in fewer referrals to DYFS and fewer boarder babies, but more significantly, the assurance that women receive adequate health care, and referral to substance abuse treatment and other services, during their pregnancy and the postpartum period.

**Child Protective Service Response**

As required by statute and policy, families of newborns at high risk continue to be referred to the Division of Youth and Family Services. Prior to the implementation of the Newark New Start Project, these referrals came to the intake units of the five Essex County District Offices. Case managers in these units, were assigned all referrals of abuse/neglect in their assigned geographic area. By policy their primary responsibility was to respond to the cases at highest risk, usually children living in their own homes. Referrals of infants in the hospital were considered to be “safe,” and therefore, at a lower level of risk. These referrals often did not receive an immediate response.
As a result, the mothers of newborns frequently had already left the hospital before a CPS response could be made. This resulted in delays in planning for the child with the birth mother, in determining the level of need she had, and in identifying alternative caregivers such as relatives who could assume full-time care of the child or otherwise support the birth mother.

Since the inception of the Newark New Start Project, specially trained and designated DYFS casework staff, as well as the Project Manager and administrative staff of the Metropolitan Regional Office, have been assigned to visit the hospital on a regular basis, and conference potential cases. They are also on-site to receive referrals from hospital social workers. (These DYFS case managers are assigned to the project at no cost to the grant budget.)

These designated case managers provide expedited and intensive child welfare services to at risk newborns. They work in consultation with the hospital social workers to determine whether a child is at risk and needs referral to DYFS, or can be safely diverted to New Community Corporation for family assessment and intervention.

The following are risk indicators that would require a referral to DYFS: positive toxicology for drugs/alcohol by the mother and/or the child, previous DYFS history, lack of prenatal care, and concerns about the care of siblings.

One of the unique components of this project is the on-site presence of these DYFS case managers at the hospital. These case managers provide an immediate response to the hospital, and meet with the mother at the hospital, and are often accompanied by the Certified Alcohol and Drug Counselor (CADC) attached to their unit. Their presence in the hospitals expedites the development of the child’s case plan.

This on-site presence allows for the immediate access to the mother or family members who may visit, and therefore the ability to obtain vital relative resource information, and early drug assessment and treatment intervention.

The DYFS worker assesses the situation in relation to the mother’s ability to care for the child, and based on that assessment, develops a child welfare plan for either discharge to the mother, discharge to relatives, or discharge to foster care. Additionally, the specialized worker has daily conferencing with hospital and social work staff, daily visits to assigned hospitals, contacts with each nursery, and is available to sign any consent forms needed.

There are currently six specially trained and designated Division workers, under the supervision of a unit supervisor, who work only with boarder babies and their families in Essex County. These workers and the unit supervisor are linked to management through monthly reporting, immediate on-site access, and monthly team meetings. Daily referrals are tracked and monitored by the Specialized Unit Supervisor, with intervention from the Project Manager as needed. His services are provided by DYFS at no cost to the project budget.


Caretaker Assessments and Family Supports

Prior to the implementation of the Newark New Start Project, the need to assess relatives as alternative caregivers constituted a substantial barrier to the discharge of the child from the hospital. The case managers at the DYFS Newark District Offices were required to prioritize investigations of serious abuse or neglect in the community and did not have the capacity to complete these relative assessments in a timely manner.

Noting that two-thirds of boarder babies were ultimately discharged to relatives or the birth parents, the project planners identified rapid assessments of relatives and birth parents as a major strategy to facilitate discharge for these children. This resulted in contracting with the Newark Family Resource Network (NFRN) to perform these assessments.

Women assessed by DYFS as unable to care for their children are asked to identify an alternative caretaker. Utilizing the services of Newark Family Resource Network, these potential caretakers are assessed within 24 hours to determine their willingness and appropriateness to care for the infant. If the initial assessment is positive, the DYFS caseworker visits the caretaker, confirms the appropriateness of the assessment, and finalizes the case plan, including the provision of needed supports and services.

To date, NFRN has received 1,038 referrals, which has resulted in the completion of 1,214 assessments of potential caretakers.

Substance Abuse Intervention

The Newark New Start Project makes available a wide range of services to substance abusing women, to address their need for treatment, prenatal care, and appropriate social services. Project staff provide training on protocols and resources for physicians, nurses, and social workers, and participate in the development of local systems to assure linkages to substance abuse treatment facilities. The project itself does not provide substance abuse treatment, but is dependent on existing community treatment providers.

The Division had identified the availability of a Certified Alcohol and Drug Counselor (CADC) to assess clients in their own homes (where possible) as a key to achieving a successful referral to treatment services. In Essex County, a CADC has been attached to this project at no cost to the grant.

DYFS case managers arrange for a CADC under contract with the Division, to assess women with identified substance abuse problems. Frequently, these assessments are made in the maternity ward following the birth of the child. This has been proven to be a critical time to convince mothers to accept treatment services.
The CADC works in conjunction with a home visitor to provide assistance in getting these women into treatment, provides peer support, transportation, and related substance and alcohol abuse services.

Supportive Services for Mothers Receiving Substance Abuse Treatment

Given the very high incidence of substance abuse among the families with boarder babies (77%), the project planners developed a component to augment and support the substance abuse treatment services that would be offered to those families. Noting that the period immediately before and following substance abuse treatment is a critical time in terms of relapse and return to drug use, the project sought to provide a support person who could address the issues facing the newly recovering addict/alcoholic or the addict/alcoholic having second thoughts about following through with treatment.

A peer home visit from NFRN, (who may be a parent, in recovery from an addictive illness, and has been drug and alcohol free for at least two years), is provided as a role model for clients. Role modeling occurs by developing supportive relationships, providing hands-on parenting training and encouraging clients to remain drug-free. Transportation and introduction to Twelve-Step programs are also included in these services.

Role of Paralegals

Not all of the children served by the project can be returned to their birth parent or relatives. To facilitate permanency, the Newark New Start Project utilizes two paralegals in Essex County to address such vital litigation tasks as preparation of custody applications, other court documents, and the legal work necessary prior to placement in temporary foster homes or foster/adopt, and pre-adoptive homes. An additional vital role of the paralegals is the completion of searches on missing parents and relatives. Once located, these individuals and families are assessed to determine their capability to provide for the care and safety of the infant.

Family Preservation Services

With the goal of either preventing out-of-home placement or stabilizing the home for family reunification, this intensive, home-based service will continue to be specially funded for Essex County. A contracted family preservation services worker provides therapeutic, educational and supportive services in the home of the client. (This service is provided at no cost to the project budget.)
Pediatric Nursing Services

A Pediatric Nurse Consultant (PNC) provides medical assessment of infants in boarding status to assess medical needs and expedite discharge planning. The PNC has daily contact with the project hospitals and assists workers with medical consultations, identification of special needs children and appropriate referral when the child is HIV/AIDS exposed. The PNC is funded through state dollars at no cost to the project.

Additional Program Services

The Division of Youth and Family Services’ continuing commitment to resolve the boarder baby crisis has been clearly demonstrated throughout the history of the Newark New Start Project. As such, Newark New Start is the foundation of a larger effort to address the boarder baby problem. Through the four years of the project, DYFS has provided substantial funding specifically for this project, to provide additional valuable resources for the populations served by the Newark New Start Project.

In addition to some of the services noted above, the following supportive services and interventions are provided by Division funding for the Newark New Start Project at no cost to the project.

Supervising Housing This service provided by Isaiah House in Essex County, is a mother-child supervised housing component that provides comprehensive interim care for mothers and their newborns who are medically clear to leave the hospital and who would otherwise enter the foster care system. Culturally sensitive peer workers provide supervision, while mothers can care for and bond with their new child, and at the same time have access to substance abuse treatment, parenting education, and other resources. The parent is also assisted in finding permanent housing.

Reunification Services These services, provided by Babyland Inc. and Harvest of Hope Inc., provide intensive visitation between natural mothers and or relatives who may become the primary caretaker for a boarder baby. The program was developed to encourage and support the mother-child bond as soon after birth as possible. Transportation is provided to the location of the baby, mother or relative at a convenient visitation site. Additionally, efforts are made to connect or reconnect infants who are abandoned at the hospital with their mother or potential caretaker through visitation until the child is placed in a permanent setting.

Foster Home Services The lack of foster homes was a major concern identified in the initial grant application. In recognition of this, one of the funded components was a foster home recruitment program. The contract with this component was terminated due to contractual concerns, and the funding was redirected towards other programmatic areas; however, the lack of foster homes continues to remain a major barrier to the discharge of newborns who cannot be returned to birth parents or relatives. As a result, DYFS has provided substantial resources directed to address this need. Through DYFS’
Foster Care and Permanency Initiative, enhanced recruitment efforts and increased support services for foster parents and foster children are expected to increase the pool of foster care providers for border children. These initiatives (at no cost to the grant) include:

- Expansion of infant foster care home availability through contracted foster care. This service is provided through the recruitment efforts of eight community-based foster home agencies located throughout the Metropolitan Region. This expands the much-needed availability of foster homes in all three counties.

- Expansion of foster home availability through foster home recruitment. This service is provided by Harvest of Hope and Just Babies, in Essex County. This specialized recruitment includes faith-based and grassroots efforts to find homes for infants, sibling groups, HIV/AIDS exposed children and other children with special needs.

- The Fost/Adopt strategy which has been successfully implemented within the Region. Its goal is to find permanent homes for children under the age of five within the first year that they enter the foster care system if reunification with their parent is not likely. Unlike a traditional foster home, the fost-adopt parent agrees to the temporary placement of the child, but it is also willing to adopt the child should this become the case goal.

IV. RESULTS AND BENEFITS TO THE CLIENTS

The Newark New Start Project has always had as its immediate goal the reduction of infant abandonment rates for all of Essex County, NJ. As a first step towards this goal, the program focused on the prenatal risk of infant abandonment. Through the development of interagency collaborations, more efficient assessment procedures, increased availability of postpartum family services, and the greater availability of foster home resources, the program was designed to have a direct impact on the length of hospitalization after medical clearance.

The results to date have been impressive. While serving approximately 1,914 infants and their families during its first three years of existence, the program affected a 77% decline in the average length of hospitalization after medical clearance of newborns. Given that the target population is all at-risk births in the county, the results accrue to the community in general, and to substance abusing women (over 77% of mothers served) and HIV-infected women (over 3% of mothers served) in particular.

Broader Benefits

To our knowledge, no program has attempted to reduce infant abandonment on such a large scale before. The extensive data gathered on the effectiveness of the program to date provide useful information concerning the potential of prenatal/postpartum programs for addressing the problem of infant abandonment. They also provide baseline data for evaluating the impact of adding a prenatal component.
Based on these considerations, the results could have important implications concerning the incorporation of prenatal services into child welfare services. Thus, the results are thought to have immediate implications for national child welfare policy and research into effective methods for child welfare agencies to reduce infant abandonment rates.

Outcome Analysis

Since its inception in 1996, the Newark New Start Project has achieved three key goals. First, it can be demonstrated that the program has significantly reduced the length of infant abandonment in Essex County for all at-risk newborns, including those of substance abusing and HIV positive women. Second, the program has increased access to community services for all women and their families who receive custody of their children at discharge. Finally, the program has changed the nature of interagency collaboration concerning infant abandonment within Essex County.

Impact on Infant Abandonment

The Newark New Start Project was specifically designed to reduce the length of infant abandonment countywide. The Division of Youth and Family Services (DYFS), which serves as the lead agency in the Newark New Start Project, is the child welfare agency to which all infants at-risk of abandonment are referred. Prior to initiation of the Newark New Start Project, infants referred to DYFS from Essex County spent an average of 45.7 days in the hospital after they were medically cleared. Data collected through the first three years of the project indicate the mean length of stay after medical clearance has declined to 10.5 days, a 77% improvement. Among those referred to New Community Corporation (NCC), which serves as an alternate to DYFS referral for moderate risk cases, the mean is 2.6 days.

Several statistics demonstrate the enormity of the problem the program attempts to address, and the difficulties faced by member of the population served by the Project. In its first three years, the program served approximately 1914 infants. Over 96% of the mothers were unemployed, over 92% had no insurance, and over 95% were unmarried. Even so, 21.8% of these women were receiving no benefits (AFDC, WIC, Medicaid, etc.) at the time of their child’s birth. Approximately 55% had a previous history of involvement with DYFS. Based on multiple sources of data, it is estimated that at least 77.1% were abusing drugs at the time of birth, although only 28.4% of drug-abusing mothers were receiving substance abuse services at the time and 24.9% had never received services. Infants have demonstrated a variety of medical problems, including low birth weight (45%), neurological problems (93%), and HIV (3.8%).
Availability of Services

In response to these needs, the Newark New Start Project dramatically increased the availability of community programs and the efficiency of the referral process for these families. For example, over 90% of families working with DYFS increased their access to assistance programs such as Medicaid and AFDC. Furthermore, 64.8% of women referred to either DYFS or NCC were successfully involved in drug treatment by the time they were discharged from the program, and 25% were successfully involved in an educational or job training program.

Increased Interagency Collaboration

The success of the program has required dramatic increases in the level of interagency collaboration among agencies in Essex County. Each month, representatives from DYFS, NCC, the participating hospitals, and the community agencies serving at-risk families in Essex County meet to discuss the progress of the program and develop plans for the future. Through case consultation, review of caseload, and identifying obstacles to care, these meetings are an important element of increasing the efficiency of service provision for families served. Such countywide interagency collaboration did not exist prior to development of the New Start Project.

Building on Progress

The proposed expansion builds closely on the results of previous evaluations. While a 77% improvement is notable, it still means that the majority of at-risk children spend more than three days in the hospital after they are cleared for discharged. As noted previously, statistical results suggested more than half of mothers identified as at risk at birth were already known to DYFS, and most had inadequate prenatal care. These findings set the stage for prenatal expansion. Prenatal expansion of the program will require additional interagency collaboration, as DYFS develops a system of intervention for pregnant women.

Discharge delays continue to occur because of the continued use of illegal substances by pregnant women, their failure to obtain prenatal care, and the shortage of appropriate placements for their children. To address this issue, it became increasingly important to work with the family before birth, and develop a permanency plan by the time the child is born. By working with families prenatally, the potential exists for reducing the rate of out-of-home placement. This has important benefits for the families served, by improving family environments and reducing family disruption.
V. PROBLEMS/SOLUTIONS

PROBLEM:

One of the major obstacles faced in developing the project was the lack of interagency collaboration for the boarder baby population. Prior to the Newark New Start Project, most of the organizations working with these children and their families functioned independently and/or without any coordination.

SOLUTION:

A series of protocols governing interagency collaborations was developed. For example, protocols for the hospitals listing the characteristics that defined an at-risk newborn were developed, as well as guidelines for agencies that conduct family evaluations, methods for determining community referrals, and time frames for completion of these evaluations and referrals. Similar protocols were developed for DYFS workers and key agencies involved in placement evaluation and service provision.

Also, monthly meetings open to all participating agencies were scheduled and typically have involved at least ten service providers. These meetings have allowed for discussion of continuing obstacles to service provision, for the review of data and program outcomes, for clarification of protocols, for the identification of additional community resources, for planning of the direction of the project, and as a result have molded a broad community collaboration. This has worked in the best interests of the children as a group of agencies have become invested in identifying a placement solution for each child.

PROBLEM:

The Newark New Start Project was originally intended to intervene with a child on both a prenatal and postpartum basis. Four years of experience have taught us that this approach has not been entirely effective in eliminating infant abandonment because high-risk pregnant women have typically not received prenatal care. As a result, too often these women appear in hospital emergency rooms at the time of labor, with no plan to care for their newborn infant.

SOLUTION:

As noted previously, the Newark New Start Project was the catalyst for the identification by University Hospital of high-risk women (no prenatal care and/or using illegal substances.) Pregnant women meeting either of these criteria are identified by the clinic or emergency room and referred to the OB/GYN clinic. If the woman does not keep her appointment at the clinic, an outreach worker is assigned to follow-up.
PROBLEM:
Some children have remained in hospital boarding status not only because of the lack of a relative caregiver, but also because of the unavailability of a foster home.

SOLUTION:
The DYFS has implemented a statewide foster care reform initiative aimed at improving and increasing the network of homes. The project is looking towards the greater availability of homes especially for those borderer children with special medical needs.

PROBLEM:
Some borderer children who are placed in foster care cannot be returned to their parent(s) or relatives.

SOLUTION:
The project has worked towards expediting permanency for all children placed in foster care through implementation of the Adoption and Safe Families Act (ASFA) requirements and DYFS permanency reform initiatives.

PROBLEM:
It is evident that a large percentage of the project families consist of women who have given birth to more than one borderer baby. These are women who are transient, have long histories of substance abuse, and repeated involvement with DYFS. Historically they have lacked access to prenatal care, general health care, and family planning.

SOLUTION:
Early identification methods are being developed to locate these women in the DYFS caseload and the caseloads of their community-based programs. The provision of substance abuse treatment, family planning services, prenatal care planning to identify and to assess potential caregivers, and expedited permanency planning will be offered.
VI. EVALUATION RESULTS

Results of the First Three Years of Operation of the Newark New Start Project

Evaluation of the project has been supervised by Robert McGrath, Ph.D., Director of the Ph.D. Program in Clinical Psychology, at Fairleigh Dickenson University since 1996. Prior to the funding of the Newark New Start Project, the City of Newark had one of the largest populations of children in boarding status in the nation. Children resided in hospital settings while overburdened DYFS case managers sought to find frequently addicted mothers to plan for their children, obtain resources for these families, and expedite permanency.

However, data collected from the Newark New Start Project since its inception in October, 1996 to the completion of its third year in September, 1999 show some striking results.

- During its first three years of operation, the Newark New Start Project served 1,914 children and their families in Essex County:
  - Year 1 (October 1996 – September 1997): 702
  - Year 2 (October 1997 – September 1998): 638
  - Year 3 (October 1998 – September 1999): 574

  The total number of children served each year exceeds the initial estimates of the families in need of these services (originally estimated at 336 referrals of infants in boarding status from Newark and Essex County in a 12 month period). Among AIA grantees, the Newark New Start Project is a leader in the total number of clients served each year.

- In its first three years of operation, the Newark New Start Project reduced the average length of hospitalization after medical clearance for infants in Essex County by 77% from an average of 45 days to 10 days. The average time from medical clearance to discharge across all three years of the program was 10.5 days. For the six month before the program began (April, 1996 – September, 1996) the average length of stay was 45.7 day.

- Due to the collaboration of the project's partners, these infants and their families have been afforded better access to prenatal care, improved family support, and substance abuse treatment.

There has been a marked declined in the number of referrals across the first years of the project. This declined is particularly striking given that the Project was extended to all hospital in Essex County NJ during the third year. The number of infants born Essex County NJ identified as at-risk for abandonment at the time of birth is declining, even while monitoring systems have been improving.
Although, 10 hospitals participate in the Project, the majority of infants were born either at the University of Medicine and Dentistry (45.5%), Newark Beth Israel Medical Center (23.3%), or Orange Memorial Hospital (6.1%). Of this number, 74.2% were initially referred to DYFS, while 25.8% were referred to New Community Corporation (NCC).

**Background on Mothers**

The average age of the women who participated in the Newark New Start Project was 30.8 (SD=13.8). This value has been increasing, suggesting the Newark New Start Project is dealing with a progressively older group of women. They had completed an average of 10.7 years of education. They reported an average of 4.5 prior pregnancies (range 0-17), of which an average of 3.5 results in live births (range 0-13). They reported having received an average of 1.1 abortions (range 0-13). On average 1.5 of these children were living with the mother (range 0-10) in a household containing an average of 3.7 individual (range 0-15). Woman referred to DYFS were 2.8 years older on average than woman referred to NCC, had had 2.0 more prior pregnancies, and 1.6 more live births.

Over 96% of the mothers were unemployed, over 92% had no insurance, and over 95% were unmarried. The sample was 91.4% African-American, with the majority of the remaining participants Latino, and over 98% were U.S. citizens.

The next set of variables examined had to do with various sources of support for the participating families.

<table>
<thead>
<tr>
<th>Source</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>None:</td>
<td>21.8%</td>
</tr>
<tr>
<td>AFDC</td>
<td>35.3%</td>
</tr>
<tr>
<td>Medicaid:</td>
<td>54.8%</td>
</tr>
<tr>
<td>Food Stamps</td>
<td>37.1%</td>
</tr>
<tr>
<td>WIC</td>
<td>35.7%</td>
</tr>
<tr>
<td>Unemployment</td>
<td>0.0%</td>
</tr>
<tr>
<td>SSI:</td>
<td>4.8%</td>
</tr>
<tr>
<td>General assistance</td>
<td>8.8%</td>
</tr>
</tbody>
</table>

Except for a decline in the percentage receiving WIC (46.7% of mothers in Year 2), these are generally consistent with finding from the previous year.

Since participating mothers are likely to try to hide substance use, the possibility of substance abuse problems is evaluated at several points in the assessment process. A reported history of substance abuse or a positive toxicology screen can spark the assessment. The assessment itself may reveal substance abuse, or the child may prove drug-exposed at birth. Combining all of these variables to generate a best estimate of the true number of substance-abusing mothers, it was estimated that at least 77.1% were abusing drugs at the time of their child’s birth, which is slightly higher than the rate indicated in the last report. However, only 28.4% of drug-exposed mothers were receiving substance abuse services at the time of birth, which is slightly lower than in the
last report. Another 46.7% had received substance abuse services in the past, while 24.9% had never received substance abuse services of any sort. Only 2.4% of mothers were receiving mental health services at the time of birth; 90.8% had never received mental health services. Mothers served by the Project are on average getting older, and there is some evidence of more severe circumstances.

Background on Infants

On average the target child was born at 36.0 weeks gestation (range 9-42 weeks). The average birth weight for children born since August 1997 was 5.6 pounds. Although slightly higher than the mean weight reported for the mother treated during Year 2, it is still significantly less than the mean of 5.9 pounds reported for the first year. Using 5.5 pounds as the lower bound for normal birth weight, the proportion of normal birth weigh children continues to decline. Where 62.4% of babies born in the first year were normal birth weigh, among babies born in the third year only 49.6% demonstrate normal birth weigh. Furthermore, the percentage of very low birth weigh babies (less than 2.75 pounds) has increased each year of the program, from 4.8% in Year 1, to 7.4 percent in Year 2, to 9.1% in Year 3. The cases referred to NCC and DYFS did not differ significantly on these variables.

The following is the percent of target children exhibiting various medical conditions:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV+</td>
<td>3.8%</td>
</tr>
<tr>
<td>Drug exposed</td>
<td>67.3%</td>
</tr>
<tr>
<td>Respiratory</td>
<td>20.7%</td>
</tr>
<tr>
<td>Neuro Problems</td>
<td>9.3%</td>
</tr>
<tr>
<td>Premature</td>
<td>19.4%</td>
</tr>
<tr>
<td>Infection</td>
<td>16.3%</td>
</tr>
<tr>
<td>Jaundice</td>
<td>5.8%</td>
</tr>
<tr>
<td>Other</td>
<td>12.9%</td>
</tr>
</tbody>
</table>

These are all very consistent with previous findings. Although infants in the third year were similar to previous groups in terms of the frequency of medical problems; there has been a marked increase in the number of low birth weigh children.

The Assessment Process

The following is the percent of cases demonstrating each of the reasons that an assessment would take place:

Chemical use

<table>
<thead>
<tr>
<th>Method</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>by history</td>
<td>62.4%</td>
</tr>
<tr>
<td>by tox screen</td>
<td>66.8%</td>
</tr>
<tr>
<td>Mental impairment</td>
<td>8.0%</td>
</tr>
<tr>
<td>Cognitive impairment</td>
<td>6.0%</td>
</tr>
</tbody>
</table>
No housing: 10.2%
Inadequate housing: 16.9%
Domestic abuse: 2.2%
DYFS: 55.4%
Adolescent mom: 13.8%
Does not want baby: 4.2%
Prenatal care
   None: 41.0%
   Late: 8.7%
   Inadequate: 19.6%
   Mother in residential: 2.2%

In general, these are consistent with the previous report.

On the basis of an assessment requested by the hospital social worker, the following represent the percent of cases in which various risk indicators were identified:

- No resources: 24.8%
- Unprepared for baby: 53.7%
- Evidence of drugs: 64.9%
- No suitable caretaker: 18.4%
- Positive tox screen: 58.5%
- Does not want baby: 6.4%
- Unsuitable situation: 36.0%
- DYFS involved: 53.9%
- Abuse risk: 11.0%
- Caregiver:
  - Refuses custody: 1.1%
  - Refuses treatment: 6.1%
  - Cannot participate: 2.2%

Again, these are very similar to findings reported previously.

Boarder Baby Status

The mean time from medical clearance to discharge across all three years of the program was 10.5 days (SD=13.8), with a range of 0-67 days. The mean for infants seen during the third year was somewhat higher, spending an average of 13.3 days in the hospital after medical clearance, suggesting mean hospital stay increased during the third year of the Project. However, it is important to compare this number to lengths of stay after medical clearance prior to initiation of the Newark New Start Project. Based on figures provided by DYFS, the unweighted mean length of stay for the six months before the program was initiated (April 1996-September 1996) was 45.7 days.
For cases referred to NCC during Year 3, mean length of stay after medical clearance was 2.3 days, with range of 0-22 days. This is higher than the mean for the second year (1.4 days), although consistent with NCC’s performance in the first year of the project. For cases referred to DYFS, mean length of stay was 16.8 days, with a range of 0-67 days. This is an increase from the previous year's mean, of approximately 12 days.

Using the definition of boarder baby status provided in the initial grant proposal (discharge more than 4 days after medical clearance), 60.2% of cases seen in the third year were boarder babies up from 50.3% a year earlier and the 52.2% reported for the first year. Only 20.0% of referrals to NCC remained in the hospital 72 hours after medical clearance, which is consistent with their performance during the first year of the project, but not as good as the 8.3% reported for the second year. The percentage of children referred to DYFS who remained hospitalized 72 hours after medical clearance increased from 61.8% to 73.2%. The most common reasons for remaining in the hospital continues to be incomplete evaluation (57.1% of boarder babies) and absence of a suitable placement (36.5%).

Part of the problem is reflected in data on the caretaker upon discharge. While mothers continue to represent the largest single group of caretakers after discharge, the percent discharged to mother declined from about half to only 43.0%. At the same time, the percent of discharge to DYFS remained relatively constant (28.1%). Discharge to other relatives requires evaluation of more homes than in the past. This is additional evidence supporting the hypothesis that the circumstances of mother is served by the program have deteriorated.

Boarder babies in the third year of the Project were almost twice as likely to demonstrate neurological problem, and three times as likely to be HIV positive. In addition, 84.6% of boarder babies were drug-exposed, as opposed to 53.5% of infants who did not meet the 72-hour criterion.

Implications for Practice

Significant to the past success of Newark New Start has been the willingness of DYFS administrative staff to modify case practice and to institute organizational changes in order to achieve better outcomes for children. Examples of this include the development of immediate hospital response capacity by DYFS case managers and the assignment of dedicated caseworkers who specialize in services only to boarder baby cases.

The commitment by DYFS to improve its case practice continues. Case practice reviews will take place in the following areas:
• Improved services to women who have delivered a boarder baby

Child welfare practice too often focuses on permanency planning for the infant placed with relatives, or adoption, if family reunification has been ruled out. Since the mother is no longer a placement option for the child, her case is closed. As a result, the mother often continues her long involvement with substance abuse, and if she subsequently becomes pregnant, does so without prenatal care. Repeated case openings and closings that address only the current infant at-risk lead to loss of continuity in case intervention, resulting in mothers having successive boarder babies.

During the next round of grant funding, however, practice modifications will be implemented. DYFS will continue to work with mothers for specified periods of time, even if a child is permanently placed with a relative. By continuing to work with the mother of a boarder baby and engaging her in project services, the likelihood of her giving birth to another boarder baby will be decreased.

• Achieving family stability through family planning education

In current DYFS case practice, limited attention is given to family planning. As a result, women who are least able to assume responsibility for a child have limited access to family planning information and services. This leads to the possibility for additional pregnancies for which the woman is not prepared.

During the next round of funding, this area of DYFS case practice will be expanded so that DYFS caseworkers will be expected to address family planning issues with women. Community resources will be identified and staff will be trained to make appropriate referrals to community agencies. Women who have had one or more boarder babies will need more intensive intervention to assist them in making family planning choices.

This approach will provide options for the mother before she becomes pregnant. As a result, the incidence of children in boarding status may be further reduced, and the risk of HIV infection to the mother and the child will be dramatically affected.

• Need for intensive outreach services

The Newark New Start Project mobilized the Division’s casework resources and provided the stimulus for case practice changes that have resulted in immediate DYFS response to hospitals. This approach substantially improved DYFS access to women who just delivered an at-risk infant. Unfortunately, these women tend to be transient, and difficult to serve. This is particularly true for child welfare caseworkers who have multiple responsibilities. Outreach workers who have been assigned to work with these women have been invaluable in locating women “lost” to traditional social service programs, and have been able to bring them back to services.
Need for Continued Collaboration

The Newark New Start Project provided the framework for agencies to come together to address a critical community problem. Although DYFS took the lead through the grant, the Newark New Start Project was also successful in understanding that this was more than a child welfare problem. Rather it had numerous causes, including access to health care, substance abuse treatment, poverty and housing, to name a few. Successful efforts to ultimately resolve this problem will require greater participation from public and private agencies that have responsibilities in these areas.