The Boarder Baby and Foster Care Crises in New York City: Problems of Policy and Poverty

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THE BOARDER BABY AND FOSTER CARE CRISSES IN NEW YORK CITY: PROBLEMS OF POLICY AND POVERTY

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The plight of The City's so-called "boarder babies" is one manifestation of the broader problem over which child advocates have lamented for the past fifteen years, namely, the absence of a broad-based family policy. In fact, boarder babies and their older siblings in New York City face a harsh economic reality.

Consider the facts. Close to seventy percent of boarder babies are Black and virtually all of them are from poor parents. The 1980 Census counted 552,390 Black children in New York. Close to forty percent of these children live on incomes below poverty levels. Food, shelter and clothing for these families and children are too frequently derived from the basic welfare grant which is inadequate to meet their needs. Unlike other entitled income, this grant is not indexed to the Consumer Price Index, and resources for basic items such as food, shelter and clothing consistently lag behind the actual cost of these items. Thus, poor children are often exposed to malnutrition with debilitating consequences which cannot be reversed within two generations. They are often inadequately housed, living in overcrowded conditions, shelters or welfare hotels. In addition to deficient grants, it has been estimated that the Human Resources Administration's "churning" procedure exposes 150,000 children annually to hunger and homelessness for at least one month.

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1 See infra text at note 9 for definition of "boarder babies".
4 Id. See also Rich, Census Figures Find 1 in 5 U.S. Kids Live Below Poverty Line, The Star Ledger, Nov. 24, 1989, at 69 [hereinafter Rich]. (1989 Census Bureau survey showed that 19.7 percent of children lived in poverty in 1988, "half again as high as the national poverty rate of 13.1 percent of all persons . . . . Among [B]lack and Hispanic children, two in five were poor." The Government's official poverty line in 1988 was $9,435 for a family of three.) For children under six years old in 1989, half of Black children, 40% of Hispanic children and 17% of white children were poor—defined as $12,675 for a family of four. Pear, U.S. Reports Poverty Is Down but Equality Is Up, N.Y. Times, Sept. 27, 1990, at A14, col. 1.
5 PETER E. MEYER, The Exploitation of the Growing Class, CHILDREN'S LIBER- 
   ATION (David Gottlieb ed. 1973) at 49.
6 Too Little Too Late: New York State's Increase To Its Public Assistance Fam-
   ilies, Research Notes of the Community Council of Greater New York, April 1986, 
   No. 61.
7 The In-Human Resources Administration's Churning Campaign, Children, Youth And Families in the Northeast: Hearings Before the Select Committee on Children, Youth and Families, House of Representativies, 98th Cong. 1st Sess. (July 25, 1983). "Churning is the term used by HRA to refer to the practice of closing cases for 'administrative reasons.' This cost-saving device allows HRA to close the cases of eligible families and children for a month until the case is re-
   opened." During this period of one month to six weeks, would-be recipients have no money to pay rent or feed their families. Id.
Despite these economic realities, the "boarder baby" problem receives the bulk of media attention. This attention was a primary result of the high costs of maintaining these infants in hospitals, the explosive interest shown by local politicians (such as Mayor Koch's 'I want you to have my baby' campaign), the deleterious effects on child development, and the problem's high correlation with the City's drug of choice - crack cocaine.\(^8\)

In this article, we will examine the conditions which have created the boarder baby epidemic and the attendant problem of lack of availability of foster care. We will briefly examine the social, cultural, psychological and political parameters which have determined the dynamics of this problem. Finally, we will review some earlier attempts toward the resolution of the problem and provide an overview evaluating the bona fides of those approaches. Our analysis will also draw upon relevant events which have occurred in other American cities that help us to understand this problem.

### II. Description of the Problem

#### A. Nature and Extent of the Problem

"Boarder babies are children under age two who remain unclaimed in hospitals after being medically cleared for release. Most await placement in foster care."\(^9\) Typically abandoned by their parents, these children are often afflicted with AIDS\(^10\) (Acquired Immuno-Deficiency Syndrome) or addicted to "crack"—a highly addictive, smokable derivative of cocaine which produces an instant "high" in five to twenty minutes. They are frequently children who are abandoned, physically or mentally handicapped, or who exhibit "neonatal abstinence syndrome" (infant withdrawal).\(^11\) This latter population forms the crux of the boarder baby problem which came to a peak in New York City in the spring of 1986.

It is well documented that children of female drug-abusers are frequently sentenced in utero to a plethora of physical, psychological and social handicaps which no amount of postnatal intervention can ever completely remediate.\(^12\) This reality combined with documentation of the

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\(^12\) M. GREEN AND F. SUFFET, *The Neonatal Narcotic Withdrawal Index: A Device for the Improvement of Care in the Abstinence Syndrome, Pregnant Addicts and Their Children*, at 84 (Richard Boatman *et al* eds., Center for Comprehensive Health Practice, New York Medical College).
inability of addicted women to function as parents led some states, most notably New York, to refuse to release these children to their mothers without custodial mandates by protective services. Thus, the salient features necessary for a boarder baby crisis were in place awaiting an exponential increase in the number of women drug abusers of child-bearing age. New York City has had great difficulty in providing adequate shelter for these children abandoned to the care of municipal authorities who house them “temporarily” in hospitals and other hospices.

This “boarder baby” crisis is largely a result of four major factors: the crack epidemic; long-term dependency created by other drugs; the increase in the social acceptance of single-motherhood; and the AIDS epidemic. The babies, perceived to be desperate for love, are often not afraid of strangers; this is very unusual for children in their age group (six months to two years). Rather, the emotional and psychological deprivation they experience renders them readily available to any nurturant overture which may come to them.

The problems with foster care in New York City have been worsened by the sudden upsurge in boarder baby needs. Further, the typical length of time necessary for foster care processing caused delays in placement before New York City revised its system in 1986. New York City policy had at one time “encouraged the placing of children with families of their own ethnic background.” However, in early February 1986, the Human Resources Administration (HRA) revised its policy to place children in foster homes regardless of race. Also, potential foster parents’ reluctance to take boarder babies (or other babies born of parents who use crack or other drugs or who may have AIDS problems) exacerbates the crisis in placement.

According to sources reporting in 1987, “[o]n any given day in New York City, about 170 babies languish in public and private hospitals for lack of foster homes.” One year later, observers indicated that the presence of boarder babies in New York City public and private hospitals was
estimated at three hundred; "[two hundred] in municipal hospitals and
about 100 in private, voluntary hospitals."21

With about 18,000 children in its foster care system in 1986-87, city
officials housed many infants as boarder babies in hospitals.22 To care for
these children, a program of training volunteers to provide one-on-one
care to these infants in group homes has been initiated.23 On the average,
such group homes cost approximately one hundred dollars per day as
compared to twenty dollars per day for individual foster care.24 Medicaid
reimburses hospitals only for the first ten days of care, with costs ranging
from two thousand to six thousand dollars for this period.25 Five million
dollars is the cost estimated by the Greater New York Hospital Associ-
ation as the amount for private hospital boarder baby care for 1986 in
New York City. That figure represents only the private hospitals which
carry one third of the burden of care. The infants remain in hospitals for
an average of thirty days, with some staying for months.26 For 1987 alone,
estimated costs for the care given to boarder babies in private nonprofit
hospitals was five million dollars. Foster care stipends ranged from $288
- $420 per month, depending on the child's age and allowances for nec-
essary clothing.27 In essence, both private and city hospitals spend mil-
ions of dollars a year for the care of boarder babies.28 The discrepancy
in city priorities is further illustrated by the fact that only ten to fifteen
dollars a day typically is allowed for expenses incurred by foster parents,
whereas hundreds of dollars a day are spent for the institutional care of
healthy children.29 In effect, inadequate funds are given to families who
are willing to take these children into their homes.30 It would be more

21 Tumposky, supra note 9. "As of Feb. [1988], 839 cases of AIDS have been
reported among children under age 13 in America and 271 cases among 13 to 19
year olds. . . . [E]xerts say that for every child with active AIDS, several others
are affected." AIAA, supra note 9, at 7478 quoting Carl T. Rowan, Wash. Post.,

Children develop AIDS at a faster rate than adults. Between 1988 and 1989,
the rate of children with AIDS rose 37%. Once AIDS develops, "[t]he average life
expectancy is just two years following diagnosis." Id.

22 Neuffer, supra note 10, at 32.

23 Id.

24 Emergency Nurseries, supra note 14.


26 Id. See also Goldin, Whatever Happened to Boarder Babies?, The City of New
also Navarro, AIDS Children's Foster Care: Love and Hope Conquer Fear, N.Y.
Times, Dec. 7, 1990, at A1, col. 5 [hereinafter Navarro]. As recently as 1988-89,
babies often spent their first months after birth waiting in hospitals for placement;
by the end of 1990, new social service officials claim to have eliminated much of
the wait. Id.

27 Navarro, supra note 26.

28 Lambert, supra note 10.

29 Id.

30 Id. The December 1987 deaths of two boarder babies who had recently been
placed in temporary foster care from the Angel Guardian Home, investigated by
the Brooklyn District Attorney's Office, brought the problem to the attention of
some sectors of New York City. The Home housed about twenty boarder babies
on an emergency basis—with infants to be placed with foster families within
three days.
cost effective to transfer the state funds allocated to the hospitals to support foster care and placement problems.

B. Facts About Crack-Cocaine

1. The Children

Born of mothers who often smoke multiple vials of crack per day, the children of this crisis are plagued by tremendous physical, medical, neurological and sociological problems.\(^3\)

The mortality of crack-exposed infants is three times higher than for the general population.\(^3\)2 Crack children are typically slow learners, may be slow to progress in motor skill development, and may have low sensory perception and speech abilities.\(^3\)3 Symptoms range from what appears to be extreme retardation to hyperactivity.\(^3\)4 Crack children typically have smaller heads than "normal" babies, a result of lesser brain development, leading to future developmental problems.\(^3\)5 Common symptoms from crack-exposure are seizures, cerebral palsy and mental retardation, although symptoms vary considerably among children.\(^3\)6

\(^{31}\) See Tumposky, City Plans Big Home For Babies, Daily News, Aug. 5, 1987, at 25 [hereinafter City Plans]. See also Risky, supra note 9. From Notes on babies of drug-abuse mothers taken by a registered nurse assigned to the neonatal ward. See also Quindlen, Hearing the Cries of Crack, N.Y. Times, Oct. 7, 1990, at E19, col. 2 (coming crises of crack children anticipat...
Most children have an array of symptoms with hypersensitivity, sudden mood swings, extreme passivity, apparent lack of emotion, slow language acquisition or mild speech impediment. Many are overwhelmed by stimuli like noise or piles of toys, have trouble interpreting nonverbal signals, are easily frustrated, find it hard to concentrate, and learn something one day only to forget it the next.\textsuperscript{37}

Further, crack smoke may result in injury to very young children. The range of injury includes seizures, drowsiness, inability to stand, and possibly death to the child. Hence, passive or secondary inhalation of crack-smoke, especially by very young children in a room used by crack-addicted persons, may have toxic consequences, although long-term effects are not presently documented.\textsuperscript{3}

Exactly how crack damages the developing fetus is unknown. Many experts believe that crack interferes with brain development and impairs the central nervous system and major internal organs.\textsuperscript{39} Apparently, the placenta acts like a sponge absorbing great quantities of crack; such absorption results in injury to the brain.\textsuperscript{40}

The crack devastation began in America's central cities in 1985. About 3,000 crack children are born in New York City each year.\textsuperscript{41} According to a spokesperson for the Health and Hospitals Corporation, there were 136,000 babies born in hospitals in 1988. Seven and a half percent of these babies born in public hospitals tested positive for cocaine exposure.\textsuperscript{42} The New York Post estimates that 10,000 drug-exposed children have been born in New York City with the first wave of these children due to enter public schools in the fall of 1990.

Estimates of the number of crack-exposed children nation-wide vary considerably. For example, the Federal Government estimates that 325,000 crack-exposed children are born each year.\textsuperscript{43} Similarly, the CBS Evening News predicts that there are 375,000 drug-exposed children born each year in the United States and that another 700,000 children are abused or neglected by caretakers addicted to alcohol and drugs.\textsuperscript{44} However, the March of Dimes estimates that there will be between 500,000 and four million drug-exposed children by the year 2000.\textsuperscript{45}

The addictive pursuit of crack often causes parents to abandon their child-rearing responsibilities and their children—fueling the crisis in the
hard-pressed foster care system. Crack, currently ravaging sectors of minority communities in New York City, especially Black and Hispanic inner-city neighborhoods, is spreading rapidly into other areas. Recent reports indicate that the drug rage in New York City affects one out of forty New Yorkers. Some observers suggest that 1990 may have marked a plateau or turning point in the spread of crack use. The city’s foster care costs for 1990 were 1.1 billion dollars, which is double the cost from three years ago. The foster care caseload has increased by between 500 to 1,000 children per month in New York City. An estimated eighteen percent of crack babies require intense care at birth in the amount of approximately $10,439 per child in New York City public hospitals. A recent United States Department of Health and Human Services study indicated that needed funds for medical and foster care and special education for the 8,974 identified crack babies in their first five years will amount to 2 billion dollars or $220,000 per child.

Homelessness and child abuse contribute to the problem, but crack is considered the chief cause. Since crack’s advent to New York City in 1985, the number of children in foster care has increased from 16,000 to 38,000. For New York state, the number has doubled to 55,000 in two years. By the end of 1990, the number was expected to reach 50,000 in New York City alone, according to the HRA. Today, sixty percent of all foster children are under age five—triple the number a decade ago.

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46 The Turning Point in the Crack Epidemic, Reporter’s Briefing, Oct. 30, 1990, John Jay College of Criminal Justice (Anthropology Department Professor Ansley Hamid and Rick Curtis argue that with fewer [and no new] addicts on the street and with dealers having altered their selling methods, a turning point for crack use may have arrived). See also Shenon, Cocaine Epidemic May Have Peaked, N.Y. Times, Sept. 2, 1990, at 32, col. 6 (cocaine-related emergency room visits declined for a consecutive third quarter; other studies indicate decline by casual users in households and among high school students). In this context, we note that two-fifths of America’s heroin addicts are reported to live in New York. Many are combining crack-cocaine addiction with heroin addiction: often cocaine is used as a stimulant with heroin used for a sustaining or calming effect. The double addiction is likely to increase the transmission of AIDS, since heroin injection with intravenous needles is becoming more common. Treaster, Cocaine Users Adding Heroin and a Plague to Their Menus, N.Y. Times, July 21, 1990, at 1, col. 5. See also London, Judges Overruling of Crack Law Brings Turmoil, N.Y. Times, Jan. 11, 1991, at B5, col. 2 (state district judge held unconstitutional a state law found to punish Blacks disproportionately for possession of drugs; law penalized possession of crack (engaged in more frequently by Blacks) more severely than possession of the same amount of cocaine (more frequently engaged in by Whites); almost half of the states have or are considering similar laws).

47 Bollinger and Pierson, Crack Kids: Worst Yet to Come, N.Y. Post, May 11, 1990, at 4, col. 1 (hereinafter Bollinger and Pierson (III)).

48 Id. at 23. See also Bollinger and Pierson, Children of the Damned—Crack’s Vicious Cycle, N.Y. Post, May 10, 1990, at 18 (hereinafter Bollinger and Pierson (IV)).

49 Id. at 23. See also Bollinger and Pierson (IV) supra note 49, at 33.

50 Bollinger and Pierson (III) supra note 31.

51 Id.

52 Id.
2. Crack Women

Central to this issue and excluded from the dialogue about its resolution are the women who give birth to these children. The pregnant female drug-abuser presents a complex network of problems to health professionals and service providers. Without these pivotal actors in the border baby crisis, any discussion of the problem remains incomplete. No recommendation can be complete which does not include aggressive measures to assist this population:

The effects of narcotics on the infant are complicated by the mother's poor nutrition, use of multiple drugs, lack of prenatal care, and effects of illegal, drug-centered life styles. Treatment of these conditions during pregnancy might reduce risks to the infant by eliminating certain neonatal medical complications and by improving the quality of home life for that infant. But because the grip of addiction is a complex of psychological problems, fears, the quest for drugs and avoidance of arrest, treatment of the pregnant addict requires a multifaceted approach.53

Crack has become the drug of choice for increasing numbers of young female addicts.54 The highly addictive nature of this drug causing the rapid physical, social and psychological deterioration of abusers, combined with crack's addictive nature, cheapness, availability and smokeability, contributed to a substantial increase in female drug abusers.55 While the vast majority of heroin addicts are men, women make up an increasingly large proportion of crack users.56 Crack-using women often are repeatedly pregnant as they sell sex for drugs and fail to use any contraceptives.57 They often have one crack-abused child after another. The women do not report their drug use, and not all hospitals test all newborns for the presence of drugs.58 Unfortunately for agents attempting to control the spread of this epidemic, urine tests detect cocaine only if the mother smoked during the week before delivery.59

Even if a pregnant woman smokes crack only once, she may cause injury to her developing fetus.60 Further, children may die from "passive cocaine inhalation"—the secondary smoke ingestion from crack-smokers.61 Of those who seek treatment in publicly-financed agencies, thirty-

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53 Lawson and Wilson, supra note 13, at 68.
54 Id. at A1.
55 Id. See also Bollinger and Pierson (III), supra note 47.
56 Bollinger and Pierson (I), supra note 31, at 23.
57 Bollinger and Pierson (I), supra note 31. See also Bollinger and Pierson (III), supra note 47, at 4 and 33. See also Lazarre, Crack and AIDS: The Next War, The Village Voice, May 8, 1990, at 29, col. 1.
58 Bollinger and Pierson (III), supra note 47, at 4 and 33.
60 Bollinger and Pierson (I), supra note 31, at 23.
61 Bollinger and Pierson (II), supra note 35, at 5.
four percent of crack users were women compared to twenty-four percent female addicts of other drugs. Experts have suggested that women's proclivity to crack over heroin may be explained by their tendency to avoid anti-social behavior. However, it is likely that women's tendency to avoid self-mutilation may be more of an explanation. Since crack is not injected intravenously, the stigma of immediate self-mutilation and needle marks is avoided.

A primary cause of the family devastation in inner-city neighborhoods appears to be the greater likelihood that women will be crack addicts rather than heroin addicts. Further, studies suggest that of all parents placing children in foster care, the female drug-abuser stands out as the most scarred and least amenable to presently structured child welfare services. It should be noted that current studies are more likely to focus on the heroin user, even though a substantial number of present-day female abusers are addicted to crack. Notwithstanding this information, it is worthwhile to look more closely at some of the findings on addicted women.

In a study between 1966-1971, the Jewish Child Care Association of New York examined the functioning of addicted women and how drug abuse affected their children. Reviewing the records of ninety-five such children and thirty-three of their siblings, the following information was found. These women were characterized as severe, long-standing drug-abusers who experienced varying periods of incarceration. Children from addicted parents came into child care at younger ages (2.98 yrs.) than their counterparts who were placed for other reasons (4.73 years). Seventy-five percent of the children with drug-abused parents were still in care after five years, compared with 21%-44% of the other children. Children in the drug abuse sample were also the least visited while in care. This latter finding led to the New York State law declaring children not visited in two years abandoned and free for adoption.

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62 Id.
63 Kerr, Addiction's Hidden Toll: Poor Families in Turmoil, N.Y. Times, June 23, 1988, at A1, col. 1 [hereinafter Kerr]. Recall the theory used to explain women's choice of method for suicide—use of drugs rather than guns or knives, although the latter two are frequently used by males—suggests a feminine consideration that even in self-imposed death, looks and appearances are more a part of the psychic concern for females than for males.
64 Bollinger and Pierson (II), supra note 35, at 5.
66 Kerr, supra note 63, at A1, col. 2.
67 Lawson and Wilson, supra note 13, at 69.
68 Id.
69 Id.
70 Id.
71 Id.
72 Id.
73 Id.
The economics of human services is often penny-wise and pound-foolish. Many female drug abusers, due to both personal and systemic attributes, often do not try to negotiate the child welfare bureaucracy. Instead, they abandon their children to the system and become pregnant again, thus frequenting the same destructive paths with new children.  

C. Facts About AIDS

The facts necessary to understand the relationship of AIDS to the border baby crisis are inherent in specific aspects of the disease - transmission, number of years of latency of the virus, and possible physical effects. This section addresses briefly the relevant aspects of these factors to this article.

AIDS was first diagnosed in 1981. The medical community presently has adopted the consensus that AIDS began as a primate virus that was transferred to humans. Although the exact etiology of the disease is unknown, it is believed that the virus was transferred from Central Africa through Haiti to the United States. AIDS is caused by the lymphotropic curus Type III virus (HTLV-III), the human immunodeficiency virus (HIV). The human body is rendered incapable of fighting infection when these viruses attack the immune system. White blood cells (“T-Lymphocytes”) are attacked by the AIDS virus. This attack causes a breakdown in white blood cells, weakening the body's auto-immunity system and contributing to the high mortality of AIDS victims.

As of December 1, 1990, over 90,000 deaths from AIDS have been reported world-wide. Between 1989 and 1991 in the United States, the

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75 INSTITUTE OF MEDICINE NAT'L ACADEMY OF SCIENCE, CONFRONTING AIDS (1986), at 37, 74. See also Pneumocystis Pneumonia, 30 M.M.W.R. 250 (1981).
78 See Kalish and Schlossman, The T4 Lymphocyte in AIDS, 313 NEW ENG. J. MED.. See also Selwyn, AIDS—What Is Now Known, HOSP. PRAC., at 67-82 (1986).
79 Garrick Utley, Dec. 1, 1990. See also U.S. AIDS Cases Reported through August 1990, HIV/AIDS SURVEILLANCE REPORT CENTER FOR DISEASE CONTROL, at 4 [hereinafter HIV/AIDS SURVEILLANCE REPORT]. Government estimates of the number of AIDS-infected persons have varied because of different methods (blood donor studies, military service candidate studies) which have been employed. Such estimates vary from 800,000 to 1.5 million infected persons in the United States. Hilts, U.S. Abandons Plan for AIDS Survey, N.Y. Times, Jan. 11, 1991, at A14, col. 1 (CDC drops plans to conduct nationwide study of AIDS because persons in high risk behavior categories were found uncooperative by declining to talk about risky sex and drug habits).
frequency of AIDS is projected to rise from 1,154 cases to 3,500 or 20,000 cases, depending on whether sero-positive individuals are distinguished from those having symptoms of AIDS. In parts of New York City, one in sixty infants have been found sero-positive for AIDS antibodies, forty percent of whom will develop the AIDS disease. Many of that group will not be cared for by parents since four-fifths of children with AIDS have a parent who has been infected by the virus. The AIDS virus has been detected in the following body fluids or parts: blood, lymph nodes, urine, amniotic fluid, vaginal and cervical secretions, semen, saliva, tears and breast milk. However, the primary means of transmission are semen during sexual contact, blood transfusion, congenitally at birth or by other exchanges of body fluids. According to medical experts, some children test positive at birth for HIV antibodies, but later test negative.

III. THE PSYCHOLOGICAL, SOCIOLOGICAL AND POLITICAL DYNAMICS OF THE PROBLEM

The “boarder baby” crisis took everyone in the New York City’s Special Services for Children (SSC) by surprise. The former Deputy Commission

In New York City, Blacks and Hispanics comprise about 55% of persons with AIDS; in the United States, 24% of persons with AIDS are Black (Blacks comprise only 12% of the U.S. population) and 14% of persons with AIDS are Hispanic (although Hispanics comprise but 6 percent of U.S. population). See also Altman, Many Hispanic Americans Reported In Ill Health and Lacking Insurance, N.Y. Times, Jan. 9, 1991, at A16, col. 1 (Hispanic Americans suffer at a higher rate from many health problems including AIDS—with 22% of AIDS cases among children).

AIAA, supra note 9, at 7778.
Id.
Bollinger and Pierson (III), supra note 47, at 33, col. 5 (medical experts now report that such a discrepancy is likely due to the presence of maternal antibodies in the newborn which subsequently disappear; when readings of the child’s own antibodies are taken later, they may be free of the HIV virus). See also DePalma, New Incentives for Foster Parents, N.Y. Times, Dec. 3, 1989, at NJ4, col. 5 [hereinafter New Incentives]. Further, information about AIDS and its medical, sociological and political context continue to proliferate as the disease becomes a pandemic. Relevant materials for this article appear in the following very helpful writings: Douglas Crimp (ed.), Cultural Analysis/Cultural Activism, Cambridge, Mass.: The MIT Press, 1988; Douglas Crimp with Adam Rolston Aids Demographics, Seattle: The Bay Press, 1990; Confronting AIDS (Directions for Public Health, Health Care, and Research), Institute of Medicine National Academy of Sciences, 1986 [hereinafter Crimp and Rolston]. See also Vermund, Acquired Immunodeficiency Syndrome Among Adolescents, 143 AM. J. DISEASES OF CHILDREN 1220 (October 1989). Our thanks to Katherine McFate, Joint Center for Political and Economic Studies for sharing a reprint of this article.

The Child Welfare Administration was formerly called the Special Services for Children agency (HRA/SSC).
of the New York State Department of Social Services indicated that because there were too few foster or adoptive homes to take children, a loophole in the state law would have to be used to address the problem. The New York state law forbids children under five years of age from residing in group homes designated for between six and twelve children. The loophole is that children may be placed in group homes where thirteen or more children are assigned. Babies have often stayed in these nurseries for up to four months.

Most researchers concur that crack use began in major urban centers such as New York, Miami and Los Angeles. Most of those addicted are poor or working class persons in inner city neighborhoods, but the drug has spread in the New York region effecting lower middle class working people, especially from New Jersey. Prior to 1985, the drug of choice of street addicts was primarily heroin. By the Spring of 1986, crack had become a city-wide epidemic. For the female drug abuser whose quest for drugs frequently leads to prostitution and unwanted pregnancy, a boarder baby was a tragic, yet foreseeable, outcome.

A dramatic increase in the number of children abandoned in city hospitals, born addicted or with syphilis, plus a rise in children abused or killed by drug-addicted parents has been noted in New York City's poor communities, especially in Black and Hispanic neighborhoods. While it appears that the social consequences of crack have occurred mostly in poor Black and Hispanic neighborhoods, crack addiction has also afflicted white working class neighborhoods to a lesser extent.

One of the devastating consequences of the current transition from heroin to crack as the drug of choice in poor inner-city neighborhoods is the further deterioration and sometimes destruction of the fragile single-parent household's support and care of children. This drug transaction contributes to the corrosion of inner-city minority families and the overburdening of child placement agencies. The lure of money needed to support a crack habit, which is often attained by robbery, prostitution and other crimes, has led to an increase in the level and commonality of violence as gangs vie for turf and control of this lucrative drug trade—a trade which far out distances all legitimate earning opportunities available to ghetto youth.
An important element of the crisis of care and shelter for homeless children is the environment of fear created by drug addicts and drug dealers. Even among those who refuse to be intimidated, physical violence is used to coerce compliance by the dealers and their agents. There are about 127,000 women who are heavy drug-abusers in New York City. When these women have children, the foster-care system must provide the nurturing and normal development which their mothers cannot provide. Although heroin addicts are estimated to comprise 250,000 in number, most of whom began their addiction in the mid-1960's, crack addiction is more difficult to predict. What is known is that crack is more popular than heroin and is used by a wider age group.

Reports of child abuse and neglect where there was parental involvement with drugs tripled between 1986-1988, from 2,627 to 8,521 cases. In the same period, overall statistics on child abuse and neglect were estimated at 52,568 in 1988 as compared to 41,454 in 1986. "[T]he number of babies born in New York City with drugs in their urine tripled—from 1,325 to 5,088 . . . most of whom . . . tested positive for cocaine." Syphilis, a rare phenomenon today, appeared in 160 babies born in 1987.

The child welfare system was familiar with the steady stream of 'drug babies' addicted to heroin. These infants were treated with phenobarbital and placed in foster care or with relatives until the mothers completed a rehabilitation program. The population of female addicts and 'drug babies' had been somewhat stable and 'manageable' by child welfare standards, despite the continued increases over the years. For example, in 1960, New York's Metropolitan Hospital reported a ratio of 1:164 infants affected by maternal drug addiction and 1:29 in 1973. Philadelphia General Hospital reported 1:184 in 1969 and 1:16 by 1973. In 1976, the New York Times reported eighty-seven known boarder babies in city and voluntary hospitals and a possible two hundred others which could not be identified. Thus, the problem of drug babies and boarder babies...
is not new. What caused the problem to explode in the spring of 1986 was
the fact that the City found itself with three hundred boarder babies in
city and voluntary hospitals with an additional fifty babies per month
and no plan in place to address this problem in a timely manner.105

The increase in the number of boarder babies cannot be understood
absent some perspective on the housing crisis and the problem of home-
lessness. "Local, state and federal efforts to rid public housing of drugs
has a disproportionate impact on people of color."106 Such displacement
often results in putting women, children and families in situations where
shelter provisions are jeopardized. For example, convictions of persons
for dealing drugs may mean that shelter arrangements are temporarily
or permanently altered or obliterated.

One notable consequence of the drug policy in America is its effect on
jail overcrowding:

In New York City's jails, for example, the population of women
has climbed about 33 percent in the last year. It is rising more
than twice as fast as the male jail population. Eighty-five per-
cent of these women have children, most are heads of families,
and most are African-American. Many are pregnant when ar-
rested.107

The Actors

A key actor in the boarder baby situation is the Human Resources
Administration's Office for Special Services for Children which will here-
after be referred to as HRA/SSC.108 HRA/SSC, along with private agen-
cies contracted with the City and has the responsibility of finding foster
homes for children who cannot be cared for by their families. They recruit,
certify, pay and/or monitor individuals and families who want to be foster
parents. Faced with the boarder baby problem and daily criticism from
the print and electronic media, politicians, child advocates and interest
groups, HRA/SSC responded in a manner which revealed the complexity
of red tape, conflicting regulations and absence of broad-based family
policy which characterizes its functioning. First, New Yorkers learned
that there were inadequate numbers of foster homes available to accept
these infants, despite the fact that some four thousand inquiries had come

105 Nix, supra note 2, at B1 and B5.
106 See Siegel, infra note 122, at 3. "The Chicago Housing Authority instituted
a warrantless search policy and visitor exclusion policy which would never have
been contemplated had the tenants of the projects been white." That practice has
been challenged. See Summaries v. The Chicago Housing Authority, No. 88 C
10566, U.S. N.D. Ill. See also Lazarre, How the Drug War Created Crack—The
Drug War is Killing Us, The Village Voice, Jan. 23, 1990, at 22. See also Holmes,
1 (housing law may open doors for ex-addicts).
107 See Siegel, infra note 122, at 3.
108 The New York City Special Services for Children office was later renamed
the Child Welfare Agency.
from the public in response to media coverage. Charges of mismanagement and incompetence ensued. The focal point of much of the dialogue was the fact that most of the infants were Black and Hispanic; regulations prohibiting culturally dissonant placement of children contributed to the backlog of hospitalized children pending recruitment of Black and Hispanic foster homes. HRA/SSC denied that they were bound by this regulation while private agencies indicated that they had not been apprised of any variance in regulations.

Charges of insufficient recruitment of foster families and a sluggish process of home certification were also leveled against HRA/SSC. Regulations prohibiting day care for infants placed in fosterage discouraged many working women from taking infants. HRA/SSC reported that these regulations were in the process of being waived. They also cited the hesitance of many prospective foster parents to take infants of intravenous drug users, fearing the AIDS virus.

By December of 1987, HRA/SSC head William Grinker claimed victory in the boarder baby crisis:

"[He] said the City had been able to reduce the number of babies in the hospitals, despite an increase of new cases of babies needing a place to live, to 340 total from 300 each month. "I am especially pleased because there were so many people who said you are never going to be able to do it.""

A process of "reorganization" and variances in State regulations (i.e., relaxed standards of care) made an unmanageable crisis a manageable one:

Mr. Grinker said the city had added a hundred managers, reorganized field offices to increase accountability, set up a training academy and added nearly 2,000 families willing to take in foster children. Since February, he said, the cases of 2,893 babies in hospitals were considered. Of these, 1,046 were placed in foster care; the balance were returned to their homes.

Child advocates such as the Association to Benefit Children, whose lawsuit on behalf of the babies had prompted the city's remedial action, commended the outcomes, but continued to question the overall functioning of HRA/SSC. Citizen's Committee for Children, a formidable ad-

109 Id. There was a further exacerbation of this aspect of the crisis: as foster placement began to increase, pressure was also put on HRA caseworkers to remove children from foster homes and place them in adoptive settings. The large number of cases assigned to each caseworker assured that inadequate attention would be given to each child's situation.
110 Id.
111 Id.
112 Id.
113 Id.
114 Barbanel, Number of 'Boarder Babies' Cut, N.Y. Times, Dec. 9, 1987, at B3, col. 3.
115 Id.
versary of the city’s child welfare system, called attention to that part of
the boarder baby “solution” which employed congregate care for infants
in group homes, a move previously in violation of state regulation.116

The Mayor’s eighty-nine (89) million dollar increase in foster care
spending for fiscal year 1988 can be seen as the final cement to hold the
disparate pieces of the boarder baby “solution” together. The funds are
designed to implement a new law licensing the relatives of abused and
neglected children as foster homes (“kinship homes”), increase the rates
paid to present foster parents, hire new staff for the infant group homes,
and increase the salaries of workers at private child care agencies con-
tracted with the city.117

So far, we have considered the interrelated roles of key actors in the
boarder baby crisis. These have included HRA/SSC, the media, state and
local governments and the child advocates. Attention must also be focused
on the legal contexts of the problem and various approaches used to
resolve the problem.

IV. ANALYSIS OF THE LEGAL ASPECTS OF THE PROBLEM

A. The Confidentiality Consideration: An Intractable Dilemma

The confidentiality concern focuses on agencies’ determinations as to
whether prospective parents should be told about the AIDS affliction or
drug addiction of prospective foster or adoptive children. Almost every
time a prospective or adoptive parent is told about such a condition, the
attractiveness of the placement lessens. If particular prospective care-
takers are not told about the child’s condition, then agencies may be
violating the Best Interest of the Child (BIC)118 principles. Although tell-
ing prospective caretakers may mean that they become disinterested in
the placement, not telling may mean that the child is denied the provision
of necessary health care and treatment. Further, it may be that failure
to inform potential caretakers places them at risk; risks which they could
avoid if given information in advance of the placement.

Where agencies have knowledge of the AIDS or drug condition of the
child, it is inconceivable that they would allow a placement to go forward

116 Id.
118 Homologous if not analogous questions and concerns are raised by the issue
of disclosure of the presence of AIDS where a doctor is required by a hospital to
tell his patients about his HIV infection. See Sullivan, Should a Hospital Inform
Patients If One of Its Surgeons Has AIDS, N.Y. Times, Dec. 12, 1989, at 15. See
also, Appledome, Dentist Dies of AIDS and a Florida Town Is Sad and Unsettled,
N.Y. Times, Sept. 8, 1990, at 10, col. 3 (perhaps the only known case where
transmission is alleged to have occurred from a health worker to a patient further
calls for disclosure regarding AIDS by patients and health professionals who may
participate in invasive procedures).
without telling prospective caretakers about such a problem. Often, however, especially in the case of AIDS, social placement agencies have no knowledge of the infection. HIV virus, which has been indicated as the causative agent for AIDS, may not manifest itself in children until the child is about two years old.\(^1\) Often, such children expire shortly after symptoms become discernible. In some cases, agencies may only be able to predict that children are likely to have AIDS. While even this probability should be shared with prospective long-term caretakers, such sharing of information may be counter-productive if placement is the paramount concern. This intractable dilemma creates the need not only to find appropriate placements for these necessitous children, but also means that informed consent on the part of prospective caretakers to the acceptance of a medically fragile\(^{120}\) child must be a consideration of the placement agency.

**B. Prosecution of Mothers for Transmission of Addiction or AIDS**

Crack mothers are being prosecuted in New York City and elsewhere for the transmission of cocaine dependency to their offspring.\(^{121}\) Pregnant substance abusers and new mothers are increasingly being subjected to an array of punitive measures, from neglect proceedings to criminal prosecution. These (defendants) are . . . overwhelmingly women of color.\(^ {122}\)

A woman in Greenville, South Carolina was the first to be convicted under a state law for child neglect of an unborn child for using cocaine while she was pregnant.\(^ {123}\) She received a five-year probationary penalty as her sentence. This punitive measure occurred in a context where at least four women had been arrested on the basis of a positive urine test for cocaine in their babies.\(^ {124}\)

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\(^{119}\) New test developed which can detect HIV virus earlier and can be used with persons in younger age groups.


\(^{121}\) Query: can crack addiction or other drug dependency or AIDS be transmitted congenitally by fathers? To be sure, fathers may transmit HIV virus to their partners who may transmit it to offspring. For crack, addiction is passed through the umbilical cord. *CBS Evening News*, (Dec. 13, 1989, Dan Rather, anchoring) (New pre-adoption screening test using DNA hair analysis allows prospective parents to determine if potential adoptees are drug-addicted).

\(^{122}\) *Notes on the Impact of the War on Drugs on the Civil Liberties of Inner City Residents and Minorities in General*, Study reported by President Ira Chasnoff to the National Association of Perinatal Addiction Research and Education in *Cocaine Moms and Babies*, Memo by Leon Siegel, at 2 (Special Assistant to the Executive Director, ACLU) [hereinafter Siegel].

The results of a six-month study of one Florida County indicated that Black mothers were 10 times more likely than white mothers to be reported for exposing their babies in utero to drugs. *Id.* at 2. *See also* Kolata, *Bias Seen Against Pregnant Addicts*, N.Y. Times, July 20, 1990, at A13, col. 1.

\(^{123}\) Siegel, *supra* note 122, at 2.

\(^{124}\) *Id.*
In jurisdictions outside of New York City, babies have been removed from their mothers based on similar positive toxicology reports and have been placed in foster care. These developments occur in the context of the unavailability of treatment facilities. "In New York City, 87% of area treatment programs have no services available to pregnant women on Medicaid addicted to crack." The pregnant addict lacks sufficient control of her social environment. She is exploited by this environment and neglected by the very bureaucracies and policy-makers who now suggest she be incarcerated.

Consider the facts. The profile of the pregnant addict more closely approximates that of a victim rather than that of a criminal. Typically, she is 19-35 years of age, functionally illiterate, unemployable and lacking in social supports. Often her family orientation is dysfunctional and/or geographically scattered, and is frequently characterized by economic and social dislocation. Homeless for three to six months out of each year, she possesses few social attachments that provide stability in her life.

Some pregnant addicts are prostitutes, but many are not. Most complete their pregnancies with little or no medical care because they are uninsured, uninformed and possess disorganized lifestyles. Most complete their pregnancies with limited or no contact with the social service bureaucracy until the protective service worker or medical social worker informs them of the baby's positive drug test and the ensuing consequences for both mother and child.

Any plan to incarcerate these women is both sexist and elitist when we consider the fact that millionaire athletes who abuse drugs are cared for by their organization and return from rehabilitation to their careers with little or no stigma. Similarly, the "Wall Street executives" who abuse drugs have access to private and confidential rehabilitation (in the neighborhood) and return to secure jobs.

Beyond this, any plan to incarcerate the addicted mother is a classic example of what William Ryan describes in his book, Blaming the Victim:

Blaming the victim is an ideological process, which is to say that it is a set of ideas and concepts deriving from systematically motivated, but 'unintended' distortions of reality. In the sense that Karl Mannheim used the term, an ideology develops from the 'collective unconscious' of a group or class and is rooted in class based interest in maintaining the 'status quo' (as contrasted with what he calls a 'utopia', a set of ideas rooted in a class based interest in changing the 'status quo').

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126 Siegel, supra note 122, at 2.
127 Family of orientation is the family from which a person comes; to be distinguished from family of procreation which the woman may be involved in orientating.
The distorted reality in this situation is that because a woman bears life she can escape (indeed must escape) the drug plague that has ravaged American society. In addition, she must do this in a period of fiscal restraint in which most resources for rehabilitation have been defunded and waiting lists abound for those still in existence. Utopia for the pregnant addict will come when we learn to address social problems themselves as opposed to punishing their victims.

V. REVIEW OF PROPOSALS AND POLICIES

Over the few years that society has been dealing with the problem of what to do about boarder babies, several alternatives have been explored. Among these options are group homes, foster care, other hospices, special education and training. Furthermore, there have been variations in the way these alternatives have been funded. This section explores these alternatives and the funding supports for them.

A. The Hospital as Home

The hospital workers often provide the first environment for growth for children abandoned to the city. Bright colors, attractive shapes, colorful posters and playful mobiles may help to put some joy and kindness back into a child’s life, but these will not stand as a sufficient substitute for the nurturing environment which a family would provide. Yet, such trappings are all that most boarder babies may expect as hospitals attempt to cope with the crisis.¹²⁹

B. Group Homes

Miracle Makers is one of several “nurseries” for boarder babies, opened under the auspices of Social Services for Children, which provides temporary care for children awaiting placement. But Miracle Makers is mandated to be closed within one year because it violated requirements for bathing and ventilation.¹³⁰ Ruth Messinger, City Councilwoman of New York, is reported to have paid a surprise visit to Miracle Makers and found the staff “coping” with a difficult situation which “is escalating out of control.” A representative of the Citizens Committee for Children says that more “talented” people and “energetic” approaches are needed to speed up the foster placement process.

¹²⁹ Lambert, supra note 10.
¹³⁰ Id. Also, the East Harlem Reception Center, which housed as many as sixty-eight children a night, was ordered by the state to close. City Plans, supra note 30, at 25.
Another approach is being tried to place these children of AIDS victims and drug addicts in group homes. Significantly, State Assemblyman Albert Vann of Brooklyn has spearheaded a drive to place these children with temporary substitute parents, such as with working families and alternative family members. Because more than eighty-five percent of the children in the foster care system are Black or Hispanic, Vann also is planning for more foster care and adoption assistance from these ethnic groups and their organizations.131

The city does have plans to open three large-scale group homes for foster babies. These would appear to resemble the era of the large orphanage. The homes, to house ten to twenty children, might be used for AIDS or mentally handicapped children, according to William Grinker, head of HRA.132 However, several experts have recommended that small group homes should be established. They analogized Hale House and Hale’s Cradle, residences for children of drug-addicted women and AIDS infants in Harlem, as the type of facility which should be created.133

C. Other Hospice Care

Use of other facilities might relieve pressure on hospitals and provide more humane environments for the dying. These should be developed for babies as well as adults. Congressman Rangel promised to check Medicaid regulations which reportedly denied reimbursements to hospice patients who spent more than twenty percent of their time in facilities other than their homes.134

Exclusion of women from drug-treatment programs has been challenged in class action lawsuits by the Women’s Rights Project of the American Civil Liberties Union and the New York Civil Liberties Union.135 A special kind of group home, the residential rehabilitation center which allow crack mothers to keep their children, has also been tried by New York City. Odyssey House once was “the sole drug-treatment center in New York State” which facilitated retention by addicts of “their children while they [addicted parents] complete a rigid program of coun-

132 Id.
133 Gross, Falling in Love: A Woman’s Fight in Foster Care, N.Y. Times, July 22, 1987, at B1, col. 1. Care costs in Hale’s Cradle were estimated at $161 daily compared to $600 daily for care in Harlem Hospital.
134 Id.
sling, group therapy and peer support.” This program of Odyssey House, designed for addicts who are parents, consists of a four-step program which begins with assigning responsibility to the addict-resident for one simple task. For example, the parent may begin by working in the laundry room and may advance eventually to a fourth stage where she will gain increased responsibility, independence and interaction through employment and will learn to earn and save on her own.

At Odyssey House, parents are required to develop “patient, loving relationships with their children.” New residents attend classes on parenting, are supervised while playing with their children, and are advised against abusive interactions, such as screaming or hitting their children. Assistance in balancing major tasks such as household chores, child-rearing, job-seeking, personal problems and peer interaction is also provided.

The Odyssey program is located on the third floor of a dormitory with two large rooms with bunk beds for mothers and separate rooms for the children, who share space with other children of like ages. The residents must follow strict rules which ban conversations between male and female residents unless others are within earshot. Violations of any of the “cardinal rules” may mean eviction from the program. Most residents do not complete the four-stages of the program but leave and/or return at various points. Less than ten percent of residents graduate from the program; a similar rate to other drug treatment facilities. Many leave as soon as they find employment.

The Odyssey House model, MABON (Mothers and Babies Off Narcotics) is singular in its acceptance of pregnant women. MABON provides a professionally staffed pre-school, pre- and post-natal care and pediatric services. In 1987, New York’s establishment of a Pre-Natal Care Assistance Program caused the number of women who received no pre-natal care to plummet from 12,225 in 1986 to 4,469 in 1988. However, eighty percent of drug-using women continue to receive no pre-natal care. In April 1986, the New York State Legislature set aside two million dollars to create centers like Odyssey House which would provide residential treatment to addicted parents and allow them to keep their child(ren) with them. In addition, in 1986-87, the Odyssey House program provided about 150 women “with education, jobs or a support network that they did not have before.”

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136 See Iverem, On Wards Islands, Center Offers Addicts Way To Keep Children, N.Y. Times, July 11, 1987, at 1, 3 [hereinafter Iverem].
137 Id.
138 Id.
139 Id.
140 Id.
141 Id.
142 Martin, Helping Parents Reclalm Children and Leave Drugs, N.Y. Times, Oct. 31, 1990, at B1 (not only mother, but also father is enrolled in program in order to maintain ties with and care for a child).
143 Suit Seeks Treatment, supra note 135.
144 See Iverem, supra note 136, at 1.
145 Id.
of detoxification before entering its program and allows a mother to bring up to two children, ages five or younger with her.\textsuperscript{46} Other than the residential program run by Odyssey House, few facilities exist to help the pregnant drug addict. Outpatient programs which treat pregnant women include the Jamaica Community Adolescent Program in Queens and the Pregnant Addicts, Addicted Mothers program in Manhattan.\textsuperscript{147} Where pregnant women and addicted mothers receive no treatment, the social, sociological and medical costs will become astronomical.\textsuperscript{148}

\textbf{D. Foster Parents Recruiting Agencies}

Two agencies have been established by New York City to recruit foster parents to care for children abandoned or orphaned with AIDS. The Leake and Watts Children’s Home in Yonkers and the New York Foundling Hospital attempt to place children with AIDS in foster homes in an effort to reduce the population of boarder babies in municipal hospitals.\textsuperscript{149}

In addition, Little Flower Children’s Services provides foster care contracts with the city to reduce the pressure from boarder baby needs. The founder of Little Flower placed an advertisement in the New York \textit{Daily News} which generated three hundred offers to accept babies. Prospective foster parents were required to take the next available infant regardless of race, religion or sex and keep the child for at least one hundred days until a permanent foster parent could be found.\textsuperscript{150} Little Flower streamlined the processing of temporary foster care applications by providing a doctor to conduct physicals, rewriting the character reference requests to convey the urgency, urging speed in checking for child abuse history etc. — reducing the usual four to six month application waiting period to just weeks.\textsuperscript{151} Further, a pre-release medical examination and a monthly physical check-up were established as requirements when two of the babies died of AIDS.\textsuperscript{152}

With reimbursement rates as much as four times greater than normal,\textsuperscript{153} potential foster parents are encouraged to care for crack-exposed,
AIDS-afflicted and other medically needy children. As part of this pilot effort, work limitations on foster parents will also begin. For example, a maximum of ten hours per week outside the home for single parents will be imposed, as well as the requirement that one parent stay home.

E. Education Programs

Education programs for drug-abusers and sexually-active persons should be expanded. Such programs were thought to be more effective among white male homosexuals than with the less educated poor. Education and training for the children themselves requires special efforts.

In Los Angeles, it costs $3,500 a year to educate a child in a normal classroom, $9,000 for each child in a special education class, and $15,000 for each child in a pilot project for drug-exposed children. Several special programs, which attempt to teach crack-exposed children, have been established in some cities. Several changes in the organization of the school structure may help drug-exposed children to progress. For example, ample warnings of imminent changes in activity should be given, a child should be assigned to the same teacher for more than one year to foster the child's trust of adults, and a networking team of experts, including parents, social workers, doctors and psychologists, should be used to encourage one-on-one attention and nurturing of the child.

F. Testing for HIV Virus

Federal Center for Disease Control officials recommend that testing for the AIDS virus be offered routinely for all patients where hospitals are located in areas with large numbers of AIDS cases. Presently, "[n]o

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155 DePalma, New Incentives for Foster Parents, N.Y. Times, Dec. 3, 1989, at NJ4, col. 5 [hereinafter New Incentives]. With an estimated need for six hundred foster care places, New Jersey has launched a one million dollar, one year pilot project. New Jersey Department of Youth and Family Services (DYFS) reported that, of the 603 children referred to DYFS between January and September 1989, 115 required specialized care, 280 were born drug addicted, and 37 had AIDS. Id.
156 See Crimp and Rolston, supra note 84, at 50.
157 Programs include Miriam de Soyza Learning Center (New York City), the Sabin Special Education Center (Los Angeles), the Operation PAR (St. Petersburg, Fla.) and the work of Dr. Ira J. Chasnoff, Director of the National Association for Perinatal Addiction Research and Education (Chicago). Turning 5, supra note 36, at B5.
158 Id.
widescale testing for AIDS is done in the public or private hospitals of New York City, which has the most AIDS cases in the nation. Before testing for AIDS, New York law requires informed consent; patients must be advised about all legal, medical and psychological aspects of the test results.

The March of Dimes Birth Defects Foundation, among other agencies, is urging women who suspect possible exposure to AIDS to get tested before becoming pregnant. Infected women have more than a fifty percent chance of passing the disease to their unborn children.

G. Governmental Response

1. Treatment

There is little coordination between governmental agencies who are assigned responsibilities which deal with the various aspects of the crack problem. In order to address the number of and severity of damage to children as a result of crack exposure, there needs to be a revolution in social care. Several experts who are dealing with various aspects of the problem concur as to the necessity for change. According to Dr. Michael Smith, Lincoln Hospital (Bronx), acupuncture and residential programs appear to be major treatment approaches since a blocker drug (like methadone for heroin addicts) is not presently available. Dr. Smith reports a sixty percent negative test ratio for crack patients treated with acupuncture—a better success rate than residential programs.

Crack-exposed children can be helped with their mental and physical impairments by comprehensive medical and therapeutic care from birth. Reporting research and observation on three hundred children who have been treated at his center for the last two years, one physician states that one-third of these children continue to show learning and behavior problems, such as short attention spans and hyperactivity.

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160 Id.
161 Id.
162 AIAA, supra note 9, at 7478.
163 Bollinger and Pierson (I), supra note 31, at 23.
164 Id. Among the experts noted are: Michael Dowling, New York Gov. Cuomo's Top Medical Advisor; Dr. Vincent J. Fontana, Chairman, Mayor Dinkins' Task Force on Child Abuse; Sandra Williams, Assistant Commissioner of New York City's Department of Mental Health, Mental Retardation and Alcoholism Services; Elizabeth Graham, Director of New York City's Mental Health Department. Id. at 3, 18.
166 Bollinger and Pierson (IV), supra note 49, at 18 (based on their interview with Dan Griffith, leading researcher, National Association for Perinatal Addiction Research and Education).
167 Id.
suggests that crack-exposed children fare better if they remain with their natural mothers. In New York City, which has only 4,400 residential treatment slots available, keeping mother and child together can be difficult. Pregnant and drug-abusing women must compete for slots with heroin addicts, who are mostly male.

Female relatives, primarily grandmothers but also sisters, are being called upon to raise the offspring of women crack-users. These kinship foster-caring structures (or "sibship" among siblings), reflect certain historic patterns of care in minority communities. According to reports of city officials, virtually all needy crack-exposed children receive foster care within a month, although few have been adopted.

Adoption may serve to reduce the number of boarder babies waiting for placement. However, without support and technical assistance from a battery of experts in psychology, neurology, speech and motor skills, these children would be doomed to a life with overwhelming problems. Requirements of treatment include intensive physical and speech therapy, nutritional care and structured play.

Treatment options would be maximized were crack mothers to receive prenatal care. It is estimated that fifty-one percent of the mothers who had tested positive for cocaine received no prenatal care. Furthermore, contraception for crack-abusing women, and all persons likely to expose themselves to the AIDS virus, must be made available.

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168 Id.
169 Id.
170 See also McCarthy, Raising Kids In Kinship, N.Y. Newsday, Nov. 14, 1990, at 6 (grandmothers and other female relatives accept, indeed often embrace, responsibility for rearing children of drug-addicted parents). Equal Care for Foster Children, N.Y. Times, Dec. 16, 1990, at E14, col. 1 (Child Welfare laws should apply to kinship homes). See Bollinger and Pierson (III), supra note 47, at 33; see also Bowen, Cultural Convergences and Divergences: The Nexus Between Putative Afro-American Family Values and The Best Interests of the Child, 26 J. Fam. L. 487 (Spr. 88) [hereinafter Cultural Divergences]; Hill, INFORMAL ADOPTION AMONG BLACK FAMILIES.
171 Bollinger and Pierson (III), supra note 47, at 33.
172 NBC News Anchorwoman (New York City) Carol Jenkins reported to the New York City Council that her experience with crack children at Hale House motivated her to adopt a crack child. Rita Delfiner, TV's Carol Jenkins Adopted Crack Baby, N.Y. Post, May 11, 1990, at 3.
173 Bollinger and Pierson (II), supra note 35, at 5.
174 Id. at 21.
175 Bollinger and Pierson (III), supra note 47, at 4, based on their interview with Dr. Howard Minkoff, Chief Obstetrician at SUNY Health Science Center in Brooklyn.
176 See also Bollinger and Pierson (IV), supra note 49, at 18 (quoting Dr. Ruth Kaminer, pediatrician at the Rose F. Kennedy Center for The Disabled Children in the Bronx).
2. Legislation

The "Medically Fragile" Child

New Jersey has defined the "medically fragile" child as one who has serious medical problems and requires special supportive measures for his/her care. On January 1, 1990, the state Division of Youth and Family Services (DYFS) began a pilot program (Special Home Services Provider Program) to encourage the nurture and treatment of babies with "chronic diseases or conditions requiring such things as special feeding apparatus, daily injections, strict diet, therapeutic counseling or care..." The program was to enroll one hundred babies in its pilot year at a cost of $900-$1200 per month for board and up to $200 monthly for foster care. This cost compares to the $400-800 per day spent to care for necessitous children who languish in hospitals.

Further, New Jersey provides additional support to families willing to take in these "medically fragile" children: up to $200 per month to pay for day care expenses, homemaking or baby-sitting services, transportation costs for Medicaid visits, and specialized training to assist in the performance of medically necessary care.

While debating whether special attention risks stigmatize these youth, some school districts have begun to train teachers to cope with this special cohort of drug-exposed children. Some experts believe that these children can progress in and out of school, even though they start school with an "absolute prescription for failure." On the other hand, places like New York and Florida, where crack's onslaught has been among the heaviest, have done little to prepare for the entrance of these children into society.

Based on recommendations of the Surgeon General's Workshop on Pediatric AIDS in 1987, Congress has authorized $10, $12 and $15 million for the years 1989-91 to study the AIDS problem, and possible solutions and funding arrangements for them. Congressional hearings to explore remedies for pediatric AIDS and drug abuse have been held by the House Select Committee on Narcotics Abuse and Control, chaired by Charles B. Rangel, Democrat of Manhattan. Other governmental reimbursement was thought to be "inappropriate", "cumbersome" and "inefficient" for the exiguous financial and health situations created by AIDS.

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178 Id.
179 Id at E2.
180 See Turning 5, supra note 36, at 1. (quoting Dr. Xylina Bean, Associate Director of Neonatology at Martin Luther King Hospital in Los Angeles).
181 Id.
182 AIAA, supra note 9, at 7479.
183 Bollinger and Pierson (IV), supra note 49, at 18.
184 Id. See also AAIA, supra note 9.
Reconsideration of some of the rules of foster care might make prospective foster parents for AIDS infants less reluctant to undertake care. However, parents' biological rights remain constitutionally protected, although abandonment may lead to the termination of those rights. A timetable based on the Goldstein-Freud-Solnit\textsuperscript{185} analysis of psychological bonding framework has been recommended. However, argument for and against application of that framework to pediatric AIDS cases is proffered below.\textsuperscript{186}

The proposal that Black children are best reared in Black homes\textsuperscript{187} perhaps has less weight and less exigency when discussing the placement of boarder babies. Situations of life and death, of suffering and pain, may outweigh cultural imperatives which remain paramount\textsuperscript{188} in other contexts. However, in a situation where care for children who are abandoned is difficult to arrange, some because they are dying, any offer of help should be accepted—readily, graciously, thankfully. In this context, there is often no time to wait to consider other alternatives. Complicating the equation here is the consideration whether drug-addicted grandchildren should be assigned to grandparent(s) who were responsible for rearing and raising their own children, children who became drug-addicted and sometimes infected with AIDS. Because Social Service departments often do not have the luxury of even multiple choices in making these assignments, we recommend that all options should be explored—placements with relatives (including grandparents), intraracial placements etc. The crisis is sufficiently severe and the resources sufficiently limited to require the greatest flexibility to placement agencies. While an argument could be made that abandonment of the cultural imperative is appropriate only for the AIDS-infected or HIV-infected child, other drug-addicted babies appear sufficiently hard-to-place. Therefore, unique criteria for placement options should be given for all of these hapless children.

A healthy self-concept for a child is determined by his experience in the family; this familial environment largely predicts the child's future relationship to society. Parents have a duty of care and support to their offspring. This duty is owed regardless of children's circumstances of birth.

\textsuperscript{185} See Goldstein, Freud & Solnit, Before the Best Interests of the Child 11, 32 (1979).
\textsuperscript{186} See, Cultural Divergences, supra note 170.
\textsuperscript{187} Id.
\textsuperscript{188} Cultural imperatives are seen as sometimes subordinate only to continuity guidelines, as explained elsewhere. Id.
Recognizing the necessity of parental nurture, support and physical care for children, [most state legislatures have] enacted a vast array of laws for the purpose of protecting or vindicating those rights. Despite the erosion of the parental immunity doctrine, courts have not tended to find parents guilty of failure to provide emotional nurturing to their offspring. Nonetheless, there still persists in society an expectation that parents will not only provide for the physical needs of their children, but will see to their intellectual, psychological and emotional needs as well.

Where a parent physically abandons a child, courts may note this abandonment as evidence that the child's emotional needs are also left unattended. Physical abandonment should be sufficient to invoke parental rights termination proceedings. Absent contrary evidence that the child is being provided with necessities, such abandonment should result in a finding of no parent-child relationship, thus freeing the child for possible placement elsewhere.

On the other hand, disruption of a child from his normal home environment is a denial of that child's basic human rights. (Later in this paper, the adoption of truncated families—especially drug-free pregnant teenagers or new mothers who are homeless—is explored). Separation of a child from his racial group, within a racist society, may often mean problems of psychological identity for those separated. In the case of Black children in America, a choice of an intraracial option is preferable to transracial placement. Given the strong extended family orientation of many Black and Hispanic families, separation of Black and Hispanic children from their extended families denies the basic human right of family integrity.

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189 Judith Areen, Cases and Materials in Family Law 749 (1978) [hereinafter Areen]. See also Areen, 162-3; Areen at 654-65 (on support obligations of mothers); Mills v. Habluetzel, 456 U.S. 91, 99 (1982) (right of illegitimate children to obtain support from their biological fathers equivalent to that of legitimate offspring); Trimble v. Gordon, 430 U.S. 762 (1977) (right of illegitimate child to inherit upheld where independent judicial action had previously established paternity). But see Lalli v. Lalli, 439 U.S. 259 (1978) (illegitimate child may not inherit where no judicial acknowledgement of paternity, even though intestate father openly and notoriously acknowledged child by several methods).


191 Areen, supra note 189, at 765 and 179-80 (1983 supplement).

192 Burnette at 707, 588 P.2d at ___. (held that parents would not be liable for the tort of parental desertion, especially emotional deprivation). This decision was premised not on the grounds of parental immunity but rather by deference to legislative prerogative and under the rationale that creation of such a tort would be antithetical to the promotion of family unity/integrity. While this overall approach must be applauded, a question must be raised as to whether there is any family unity/integrity to preserve when children sue parents on the basis of the psychological damage caused by alleged deficiencies in parenting.
2. The Compadre System

The Puerto Rican family sees itself as not just based on blood relationships but brings in co-parents (compadres) through religious rituals, such as baptism (godmother, godfather), and weddings (best man, maid of honor). Especially in baptism, godparents take on co-responsibility in raising the child. They are expected to rear the child(ren) should anything (economic, physical) happen to the parents. These persons, by agreeing to be godparents, accept responsibility for the child. If parents are alive, they take on with the parents a duty to provide discipline and economic support to the child. Compadres are extended all of the privileges of regular family membership—visitation without calling ahead, sharing in family meals etc. A family can grow in kinship and number of adults through these religious rituals. Because the majority of Puerto Rican families are Catholic, baptism and religious rituals are a central part of the culture.

The compadre system is continued to adulthood: the "compai" brother sees himself as a co-parent and takes on responsibility almost as an uncle would. A child would not tell parents that he or she was disciplined by a compai. The compai is not questioned; he has a child's best interests at heart, like the parents. The Compadre system has disappeared somewhat because of integration into the American system.

VI. RECOMMENDATIONS

The examination and collation of various approaches may be helpful in providing guidance for municipalities and other governmental entities and organizations attempting to rectify or prevent similar calamitous consequences in their jurisdictions. With this background in mind, we present the following recommendations:

1. The Pregnant Addict: Recommendations must begin with the pregnant addict.

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Within the Black extended family, similar structures are found—“play” brothers, sisters and mothers exist based on shared resources, shared experiences or both. Elements of reciprocity and mutuality are arguably more central to Afro-centric families than to Euro-centric groups. Family tends to get defined in experiential rather than biological terms.

194 See also Ghali, Culture Sensitivity and the Puerto Rican Client, Social Casework, at 459 (1977); Ghali, Understanding Puerto Rican Tradition, 21 Social Work 98 (1982).

A. Outreach mobile services: Prenatal care and social services should be taken to the streets in mobile vehicles to reach out to these mothers before delivery. In areas of communities where addicts are known to congregate, the following information on the mobile-vehicle services should be made available:

i. Early detection of pregnancy and early prenatal care: If pregnant addicts could receive tests for pregnancy and prenatal care from non-judgmental health professionals, they could be helped to understand the implications of continued drug abuse and make informed decisions around their pregnancy.

ii. Information and Referral: Women choosing to terminate a pregnancy could be referred for abortions and drug rehabilitation. Women desirous of continuing a pregnancy could be referred to drug rehabilitation and prenatal care. Women involved in high risk sexual behavior could be counseled and given birth control.

B. Drug rehabilitation: Pregnant addicts should receive high priority for entry into rehabilitation facilities. Such facilities should be expanded to address the needs of this population.

2. Foster Care for Pregnant Addicts and Addicted Mothers—

A. Foster homes should be established for first time pregnant addicts to remove them from their environment so that drug rehabilitation can be provided, as well as training in parenting and job skills.196

B. Similarly, women giving birth to addicted babies for the first time should be given the option of going into foster care with their babies, receiving drug rehabilitation and training for parenting their child.

3. Infants of Addicted Mothers: Efforts must be increased to establish permanent homes for infants more quickly.197

A. State laws must move to establish a presumption for the termination of parental rights when for six months parents have not visited or pursued custody of a child who entered foster care at birth.198

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196 Hilts, Experts Call for U.S. to Expand Drug Treatment; Bush Aides Are Receptive, N.Y. Times, September 20, 1990, at B5, col. 1 (slightly more than 2% of the U.S. population, about 5.5 million people, need treatment for drug involvement at an annual cost of about $2.1 billion or $2 billion more than current levels).
198 Id.
B. The goal for newborns entering foster care must be limited to one year if they are to be returned to their parents or relatives.

C. Court proceedings in the adoption process should be shortened; delays of time in processing legal and agency requisites, as well as delays in moving from one step to the next should both be eliminated.

4. **Change State Laws To Encourage Prospective Adoptive Parents To Adopt Both Teenage Mother and Her Child.**

A. We support the Comptroller's recommendation No. 1 to secure permanent homes for infants quickly. Legal abandonment occurs when, for six months, parents neither visit nor meaningfully pursue custody of a child who entered foster care at birth. While we allow that state law should be changed to permit that parental rights be terminated when parents legally abandon children, states should be encouraged to support adoption of truncated families: the teenage mother and her child. Because children typically will attempt to locate parents who place them for adoption and given that this new approach will enable the mother and child to be kept together, allowing for adoption of truncated families will serve two goals: (1) provision of non-state-supported homes for children and (2) maintaining the bond between mother and child. Persons who opt for this form of open adoption or fosterage should not enter this arrangement with naivety about the intense potential class conflict which may emerge. Family histories of different lifestyles, diverse cultural and subcultural values, and dissonant self-presentations may become manifest in later years as interaction around the child's development ensues. Indeed, this potential dissonance, even in same race families, appears a subject area full of immense research possibilities.

B. States should decide whether to deploy the adoption of truncated families (measure 4-A above) in an attempt to maintain the long-term welfare of the child and the emotional health of the mother. Maintaining the mother-child bond is essential to the emotional health of the child and the mother and should compel some reluctance on the part of the states to terminate permanently and early in the child's life parent-child (legal) attachments, rather than limit the amount of time allowed for reunion of parent and child placed in foster care from birth. We reach this conclusion despite the weight of evidence to the contrary supported by advocates of the BIC (Best Interests of the Child) view. Upon adoption of teenage mother and child, a family gets legal custody of both teenage mother and her child. To be sure, with this arrangement, there is no need to sever parental ties (mother's or child's) at all. This arrangement is quite similar to some arrangements in the nation which allow for adoption while not terminating biological parental rights, which are some-
times used in cases of children with developmental disabilities. At some later point, the teenage mother and/or child may choose to re-establish contact with his/her biological family. Rather than preclude this possibility, open adoption, with this truncated version, actually facilitates this option.

5. **AIDS In The Youngest Children:**

AIDS in children is different from the disease in adults with respect to transmission modes, physiological manifestations and prognosis. For boarder babies, the mode of transmission is congenitally or perinatally from a mother who has AIDS. For older children, the mode of transmission may be congenital from a mother, by intravenous drug use, sexual intercourse with an HIV-infected person or by blood transfusion.

Today, successful blood screening devices have largely eliminated blood transfusion as a means of HIV transmission. For adolescents, congenital, sexual or intravenous drug injection are the primary means of transmission. The HIV virus has a long latency period from months up to years (8 to 10 years has been specified as a possible latency period in adults). Further, the immune systems of children and adults may differ. The following are recommendations to rid this problem:

A. Increase funding research on pediatric and maternal HIV-infection.

B. Use scientific protocols which recognize and report the human life of test subjects, allowing subjects to benefit from progressive indications from the studies in which they or others are involved (i.e., do not exclude medications which indicate positive aspects in order to keep research results pure or scientific).201

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199 See AREEN, supra note 189, at 1027-1029, 1031-1038, citing In re Phillip B., 92 Cal. App. 3d 796, 156 Cal. Rptr. 48 (1979) and Guardianship of Phillip B., 138 Cal. App. 3d 407, 188 Cal. Rptr. 781 (1983) (a California case where Downs syndrome child perceived by parents as not developing properly was allowed to be given new psychological parents without terminating rights of biological parents).

200 Recommendations in this subsection are based heavily on the seminal work contained at Final Report, Secretary's Work Group on Pediatric HIV Infection and Disease, Department of Health and Human Services, November 18, 1988 (Antonia C. Novello, M.D., M.P.H., Chair) [hereinafter HIV Report] in conjunction with the important works listed at note 81 supra. Steinfels, AIDS Provokes Theological Second Thoughts, N.Y. Times, November 19, 1988, at E5, col. 1 (American Roman Catholic bishops, like many other religious groups, reject idea of AIDS and drug use as God's punishment and urge establishment of helping missions).

C. Devise therapeutic strategies which address the multi-faceted quagmire of problems confronted by boarder babies and their families: HIV infection, drug addiction (of parent and/or child), poor housing, low income, and marital instability.

D. Treatment strategies cannot and must not wait until after birth, but must begin during the gestation period. Medical intervention to diagnose and treat the fetus and pregnant mother must be developed. In this area, safe procedures must be accorded the highest priority (the old means to determine HIV infection have been found too toxic for use with children less than two years old).

E. The NIAID Pediatrics Committee of AIDS Clinical Trials Group, which is in charge of the oversight and conduct of research strategies, should be incorporated into routine prenatal intervention.\(^2\)

F. Assure the existence of adequate pediatric care treatment facilities within or proximate to areas where boarder babies and their families reside.

G. Based on the model of the Hemophilia Diagnostic and Treatment Program in the office of Maternal and Child Health Care of HRSA, deploy a multi-pronged approach including medical and dental treatment and care, genetic counseling, vocational counseling, and extension of hemophiliac services to all HIV-infected children.\(^3\)

H. Remove FDA and other institutional impediments to testing drugs on fetuses and newborns in order to allow simultaneous data development and review for infants and adults where promising indications have been found in relevant populations, adults and animals.

I. The modification of state law needs to be considered in areas where agencies refuse to allow wards of the state to participate in experimental drug research. Given the universal fatality of untreated HIV-infection, experimental drug research may be the only hope children have. Adequate safeguards to assure reasonable procedures must be developed and implemented.

J. The planned use of comprehensive and multi-faceted services approach has been found to reduce length of hospital stays; use of this approach combined with out-patient, ambulatory and community-based services should be increased—especially since these measures reduce long-term costs.\(^4\)

K. The experience of federally-sponsored, comprehensive, and neighborhood based clinics and services, which attend to culturally sensitive aspects of delivery, help reduce medical costs and suggest a model for the provision of care to AIDS patients and their families.\(^5\)

\(^2\) HIV/AIDS SURVEILLANCE REPORT, supra note 79, at 20-21.
\(^3\) Id. at 21-22, 30.
\(^4\) Id. at 27.
\(^5\) Barden, Counseling to Keep Families Together, N.Y. Times, Sept. 21, 1990, at A18, col. 1 (families receive counseling to maximize stabilizing factors and financial support in Missouri).
L. The Medicaid program may allow states (see, for example, programs established in New Jersey, New Mexico and Connecticut) to provide flexible arrangement of health care and social support services.206

6. Foster Care Recommendations:207

A. States may use various federal grants to support foster care: Title IV-E Social Security reimbursements for administrative and maintenance costs; Title IV-B formula grants for child welfare and recruitment services; Title XX Social Service Block Grants for foster parent support.

B. Recruitment of potential foster parents for children abandoned because of crack or AIDS must not be limited to families with traditional backgrounds; all possible providers of fosterage should be considered: two-parent and single-parent, able and disabled, young, prime and elderly, homosexual and heterosexual, relatives and non-relatives. (Conformable to Title IV-B & IV-E Social Security Act, as amended by Public Law 96-272, children should be placed in quasi-home environments subject to case review by caseworkers).

C. Because children under the age of three are very susceptible to opportunistic infections and may survive to adulthood despite early seropositivity reflecting maternal infection and not the child's own HIV infection, group homes should be discouraged and children should be placed in the least restrictive, most nurturing and family-like setting available.

D. Despite some public and agency sentiment against compensation for relatives to take care of HIV-infected children, states should develop arrangements to allow similar compensation for relatives as for nonrelatives; as with other children, foster children placed with relatives should have access to Medicaid, Social Security, and transportation services in the comprehensive, community-based system presently being developed and deployed across the nation.

VII. SUMMARY

New York City's boarder baby crisis highlighted the absence of family policy at the federal, state and local levels of government. It also revealed the alienation of the city's child care bureaucracy from the communities it is so frequently called upon to serve. These two areas of concern form the concluding section of this paper.

Family policy refers to laws, institutions and processes which enable the family to function as society’s agent of socialization and cultural transmission. It is also the body of laws, institutions and processes which come into play when the family fails. Institutions which converge on the family must adopt policies which complement the family rather than detract from or diminish it. Policies of other institutions inevitably influence the family whether they are governmental, industrial or educational.

Policies implementing full employment, affordable housing, income redistribution, universal health care, daycare for employed homemakers, drug education, community-based care for children unable to live at home, and community-based care for the physically handicapped, all enhance families. The current political and economic climate militates against policies which enhance families. Indeed, poor families in New York are so totally marginal to economic and social arrangements that daily living is often a struggle for food and shelter. The best evidence of the conditions in poor communities is the high infant mortality rates which exceed the rates in the larger city and, in some cases, in the nation. Family policy recognizes that these situations are untenable.

We have suggested that the boarder baby crisis raised questions around the need to include minority communities when addressing problems and planning for solutions. It is noteworthy that no minority organization (neither the Association of Black Social Workers nor Aspira nor any other) was called upon to advise or assist HRA/SSC or state and local government in the boarder baby crisis. There is little question that situations would be handled differently if community-based organizations were planning partners and monitors of HRA/SSC in serving the needs of their communities.

This paper has sought to examine the boarder baby crisis in New York City as an inevitable outcome of the absence of family policy and general conditions impacting poor children and families in the City. We have suggested that HRA’s red tape and disorganized approach to problem-solving, combined with the crack and AIDS epidemics, were the precipitating factors. We indicated that solutions proposed were little more than band-aids and relaxed standards of care. Identifying characteristics of female drug abusers led to the reality that failure to plan for them as part of the boarder baby solution was short-sighted. Finally, we suggested that only a broad-based family policy and liaisons with the minority community could address the boarder baby crisis and the condition of all the city’s poor children.

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