



Boarder Babies, Abandoned Infants, and Discarded Infants

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Definitions

Often no distinction is made between the terms “boarder babies,” “abandoned infants,” and “discarded infants.” In the interest of clarity and consistency, this fact sheet will use the U.S. Department of Health and Human Services (DHHS, 2001) definitions:

- ◆ Boarder babies are infants under the age of 12 months who remain in the hospital past the date of medical discharge. Boarder babies may eventually be claimed by their parents and/or be placed in alternative care.
- ◆ Abandoned infants are newborn children who are not medically cleared for hospital discharge, but who are unlikely to leave the hospital in the custody of their biological parents.
- ◆ Discarded infants are newborns who have been abandoned in public places, other than hospitals, without care or supervision.

Prevalence

In 1991, James Bell Associates conducted a nationwide study of boarder babies and abandoned infants commissioned by the Children’s Bureau of DHHS. In 1997, DHHS commissioned a follow-up study. This study, *1998 National Estimates of the Number of Boarder Babies, Abandoned Infants and Discarded Infants*, was designed to identify and enumerate the boarder baby and abandoned infant populations, and provided a comparison with the 1991 study. The report also attempted, for the first time, to capture data about discarded infants.

Boarder Babies

Nationally, the number of boarder babies rose by 38% from 9,700 in 1991 to 13,400 in 1998. This increase represented an expansion of the problem beyond major urban centers. In 1991, three cities (New York City, Chicago, and Los Angeles)

accounted for 47% of the boarder baby population. In 1998, those cities accounted for 27% of the boarder baby population, while the number of boarder babies in the rest of the country increased by 90%. The racial/ethnic make-up of the boarder baby population also shifted. The percentage of boarder babies who were African American declined from 75% in 1991 to 56% in 1998, whereas the Caucasian and Latino boarder baby populations almost doubled in 1998 (DHHS, 2001).

Substantial improvements were made in reducing the mean length of stay past medical discharge. The mean number of days declined from 22 in 1991 to 9 in 1998. The percentage of babies who remained in the hospital longer than 21 days declined from 24% to 12% over this same time period (DHHS, 2001).

Abandoned Infants

The abandoned infant population increased 46% from 11,900 in 1991 to 17,400 in 1998. In 1998, the abandoned infant population became more widely dispersed throughout the country, accounting for much of the increase in the abandoned infant population. In New York, Los Angeles, and Chicago, the number of abandoned infants increased 11%. However, the number of abandoned infants in the rest of the country increased 64%.

There was no change in the length of hospital stay for abandoned infants. The mean length of stay was 34 days in both 1991 and 1998. However, in 1998, there were small decreases in the percentage of abandoned infants who were drug exposed (from 78% to 72%), and those with low birth weights (from 76% to 71%). The percentage of abandoned infants born prematurely remained constant at 70% (DHHS, 2001).

Discarded Infants

Research on the discarded infant population is limited. States are required to submit data to DHHS on the number of children who enter foster care due to abandonment. However, there is no record of national statistics on the number of infants discarded in public places (e.g., dumpsters, trash bins, alleys, warehouses, bathrooms) (DHHS, 2001).

Currently, data on the number of discarded babies is difficult to estimate given that prevalence figures are determined through the use of media reports rather than official records. The DHHS (2001) study used newspaper reports from the Lexis-Nexis database to estimate the number of discarded infants. In 1992, there were 65 reported discarded babies. In 1997, 105 were reported, representing a 62% increase. Of the total number of discarded infants in 1997, 33 were found dead, compared to eight in 1992. These differences, however, may not be indicative of actual increases in incidence but rather the result of increases in media reporting.

A recent North Carolina study of neonaticide found 34 newborns who were killed or discarded by a parent within a 16-year period, 1985-2000 (Herman-Giddens, Smith, Mittal, Carlson, & Butts, 2003). This represents 0.002% of all live births in North Carolina during this time.

Characteristics

Boarder Babies and Abandoned Infants

In order to understand the phenomenon of boarder babies and infant abandonment, one must understand the magnitude of the issues confronting the mothers of these children. The mothers of abandoned infants and boarder babies have very few resources and are often struggling with poverty; insecure or inadequate housing; physically, sexually, and emotionally abusive relationships; HIV infection; mental illness; and/or drug addiction (Curran, Bankhead, & Goldberg, 2000).

Most of these mothers (63%) want to care for their infants. However, Child Protective Services (CPS) determines the safety of discharging the infant to the parents, and DHHS (2001) reports that 84% of abandoned infants, or more than 14,000 children, were expected to have out-of-home placements. Of the reported 13,400 boarder babies, 66% were expected to have out-of-home placements.

Substance abuse continues to be the most common factor in cases of abandoned infants and babies boarding in hospitals. According to the most recent *National Survey on Drug Use and Health*, an estimated 4.3% of pregnant women nationwide reported using illicit drugs within the past month (SAMHSA, 2005). In comparison, the DHHS report found that of the children tested for illegal drugs and/or alcohol in 1998, 65% of boarder babies and 72% of abandoned infants tested positive for exposure. In 1998, of the boarder babies and abandoned infants with positive toxicology screens, more than one substance could be identified in the system of each infant. Cocaine was the most frequently identified substance for both populations (DHHS, 2001).

The AIDS epidemic is taking an increasing toll on women. In 2003, nearly 88,000 women were living with HIV/AIDS in the United States, a 27% increase since 2000; moreover, a majority of these women are also mothers (Centers for Disease Control and Prevention [CDC], 2004; Forsyth, 2000). The number of new AIDS cases among children, however, has decreased since 1999 by 68% (CDC, 2004). The decline in the percentage of HIV infections among children nationally coincides with a decrease in the percentage of boarder babies and abandoned infants that tested positive for the antibody. In 1998, 4% of both boarder babies and abandoned infants tested HIV antibody positive, compared to 14% and 7%, respectively, in 1991 (DHHS, 2001). Improvements in information about transmission and methods of harm reduction, in conjunction with the introduction of antiretroviral treatment, have accounted for the reduction of the number of infants born infected with HIV (CDC, 2004).

Discarded Infants

Due to the relatively small proportion of mothers who are identified or apprehended after having discarded their infant, research on the discarded infant population and their families is limited. Data suggest that newborns are at the greatest risk of homicide during their first day of life; in fact, this time frame constitutes nearly 83% of all infants killed (Bradley, 2003). Additionally, most of these infants (95%) are born outside of hospitals (Bradley, 2003).

Available literature indicates that individuals who commit acts of neonaticide and public abandonment are predominantly young, unmarried, physically healthy women who are pregnant for the first time and not addicted to substances (Herman-Giddens et al., 2003; Kaye, Borenstein, & Donnelly, 1990; Oberman, 1996). The vast majority live with their parents, guardians, or other relatives (Oberman, 1996). These women are also generally considered to lack emotional maturity, problem solving abilities, and adequate coping skills (Drescher-Burke, Krall, & Penick, 2004). An even more fundamental similarity among these cases is denial of pregnancy and self-imposed silence and isolation during pregnancy (Drescher-Burke et al., 2004; Oberman, 1996). Moreover, women who kill and/or discard their newborns generally have no plans for the birth or care of their children and do not receive prenatal care (Pitt & Bale, 1995).

Reasons for killing and/or discarding infants include extramarital paternity, rape, illegitimacy, incestuous relationships, and perceiving the child as an obstacle to personal achievements (Bradley, 2003; Oberman, 1996). While there is no indication that this problem is limited to certain races, ethnicities, or incomes, a study from North Carolina revealed that nearly 53% of the infants killed were black, a high percentage given that black newborns accounted for only 28% of all live births over the study period (Herman-Giddens et al., 2003).

Financial and Social Implications

Boarder Babies and Abandoned Infants

The plight of boarder babies and abandoned infants is not a short-term problem, given the demands placed on medical and child welfare systems. These infants not only affect the bottom lines of many hospitals, but also can diminish patient care, as the needs of boarder and abandoned infants potentially displace other infants in need of attention.

The average cost of care per day associated with boarder babies increased 17% between 1991 and 1998, from \$478 to \$570. However, the cost of care per boarder baby has decreased slightly in 1998 to between \$2,280 and \$5,130. This is in contrast to the cost per boarder baby reported in 1991 of \$2,380-\$10,472. The decrease in cost per boarder baby reported in 1998 may be attributed to the overall decrease in length of stay. In 1998, the

estimated annual cost of care for boarder babies ranged from \$30.6 million to \$68.7 million, compared to \$23.1 million to \$101.6 million in 1991 (DHHS, 2001).

Finding suitable placements for boarder babies and abandoned infants continues to be a struggle. Children are entering the foster care system faster than they are exiting. Child welfare agencies, in their search for solutions to the overwhelming number of boarder and abandoned infants, contend with high caseloads, shortages in foster care placements, and a lack of substance abuse treatment programs for pregnant women (Maza, 1999).

Developmentally, boarder babies and abandoned infants are "at-risk." Developmental problems for boarder babies and abandoned infants have a complex etiology. Prenatal substance exposure, factors associated with parental substance abuse (e.g., no prenatal care, poor diet, inadequate housing, chaotic lifestyle), premature birth, low birth weight, medical conditions, and extended hospital stays place boarder babies and abandoned infants at risk for a range of physical, social, and cognitive developmental problems (Curran, Bankhead, & Goldberg, 2000; Frank et al., 2001; NIDA, 1999).

To address this multiplicity of issues, expedited placement in home-like settings and early intervention services are needed to assist in helping boarder babies and abandoned infants to develop normally. The postnatal environment appears to be particularly important in determining outcomes in child development (Belcher et al., 2005; Carta et al., 2001; DHHS, 1999; Hans, 2002). In fact, researchers have found that appropriate early intervention services and stable home environments can help mitigate some of the effects of prenatal drug and alcohol exposure (Frank et al., 2002; Streissguth, Barr, Kogan, & Bookstein, 1996).

Discarded Infants

The lack of existing information about discarded infants makes concrete conclusions about financial and social costs difficult to draw. A better understanding of the characteristics and circumstances of parents who discard their infants, and improved tracking of the experiences of infants who are discarded would provide a more complete picture of the societal and fiscal implications of this

problem. However, it is clear that the discarding and possible death of a newborn is of societal concern. Other issues and costs may include the emotional and physical health of the parents and the child, foster care, and adoption.

Legislation

Abandoned Infants Assistance Act

In 1988, Congress passed the Abandoned Infants Assistance (AIA) Act (P.L. 100-505) to address the growing number of infants exposed to drugs and/or HIV during the 1980s. This act authorized the Children's Bureau to provide funding to support comprehensive social service programs to serve infants and young children affected by drugs and/or HIV and their families. The original objectives of these programs included: (1) preventing the abandonment of infants and young children; (2) identifying and addressing the needs of abandoned infants and young children, particularly those with AIDS; (3) assisting infants, particularly those with AIDS, to reside with their natural families or in foster families, as appropriate; (4) recruiting, training, and retaining foster families; (5) carrying out residential care programs; (6) carrying out respite programs for families and foster families of infants and children with AIDS; and (7) recruiting and training health and social service personnel to work with such families and residential programs.

In 1991, Congress reauthorized the AIA Act, (P.L. 102-236) mandating that programs funded through the Act give priority to infants and young children who were prenatally exposed to dangerous drugs, as well as those infected with or exposed to HIV. It also promoted the concept of comprehensive service sites -- programs offering health, education, and social services at a single geographic location in close proximity to where abandoned infants reside. In addition, it expanded the focus of the program to include prevention, encouraging the provision of services to all family members for any condition that increased the probability of abandonment. In 1996, the AIA Act was reauthorized for an additional four years (P.L. 104-235) under the Child Abuse Prevention and Treatment Act emphasizing expedited permanency for infants. More recently, in June 2003, the Keeping Children and Families Safe Act of 2003 was signed by the President and became Public Law No: 108-36. This law reauthorized AIA, along with other programs, through fiscal year 2008.

Since the passage of the AIA act in 1988, DHHS has funded over 65 demonstration projects and a National Resource Center. Currently, there are 26 AIA projects: 20 comprehensive service demonstration projects, 3 family support projects for relative caregivers, 2 therapeutic recreation projects for children affected by HIV/AIDS, and the Resource Center. Located in seventeen states (CA, CO, CT, FL, GA, IL, MD, ME, MI, MO, NY, OK, PA, RI, TN, TX, and WI) and the District of Columbia, these diverse programs operate out of hospitals, community-based child and family service agencies, universities, public child welfare agencies, and drug and alcohol treatment centers.

Since 1990, the AIA demonstration projects have had far-reaching effects on the lives of children and families. Generally, parents are better able to care for their children because of AIA programs. For example, mothers were more likely to have their children residing at home after completing AIA project services than mothers who did not. Evaluations have shown that the AIA programs have increased the permanence and stability of caregiving; been instrumental in expediting hospital discharges; monitored child safety and taught parents new child safety skills; facilitated participation in drug treatment programs; worked to eliminate child abuse and neglect within program families; helped to improve parent-child interactions; improved living conditions for families; and improved the well-being of the child and family, through improved child development and health outcomes and maternal mental health (National Abandoned Infants Assistance Resource Center, 2003).

Safe Haven Laws

In response to highly publicized media reports of infants discarded in public places and left to die, since 1999 most states have passed legislation that offers a safe, anonymous, and lawful means to relinquish a newborn. Commonly referred to as "safe haven", "safe surrender", "baby drop-off", "baby Moses", or "legal abandonment" laws, these laws allow a parent to surrender a newborn anonymously under certain circumstances without the threat of prosecution (National Adoption Information Clearinghouse, 2004). The intent of these statutes is to encourage mothers, who might otherwise discard their children, to go to an

emergency room or other safe place to drop off their infants (Decriminalization of the Abandonment of Newborns, 2000).

Variations by state include limits on the infant's age at time of relinquishment (72 hours to 1 year) and the people and places authorized to accept the infants (e.g., Emergency Medical Services, hospitals, fire stations, and police stations). Most state policies adopt a "no questions asked" approach, but some states require that a person accepting the infant ask for a medical history. As of June 2005, these laws exist in 46 states (AK, AL, AZ, CA, CO, CT, DE, FL, GA, IA, ID, IL, IN, KS, KY, LA, MA, MD, ME, MI, MN, MO, MS, MT, NC, ND, NH, NJ, NM, NV, NY, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VA, WA, WI, WV, WY) (The Alan Guttmacher Institute, 2005).

The success of these laws remains to be determined. According to a report by the National Conference of State Legislatures [NCSL] (2003), approximately 33 infants had been legally handed over as of September 2001. The Secret Safe Place for Newborns program in Mobile, Alabama has been hailed as an example of successful enactment of safe haven legislation. Since 1999, nine infants have been dropped off in Mobile County (National Crime Prevention Council, 2004).

On the other hand, illegal abandonment remains an ongoing issue; in fact, California alone reported 21 cases of illegal abandonment as of September 2002 (NCSL, 2003). These figures represent estimates, as states often do not formally track the number of abandoned infants and media counts may be imprecise. Effectiveness evaluations of safe haven laws are limited and further investigation is needed to fully understand the impact of such legislation on infant abandonment.

Lack of public knowledge about these laws may be a barrier to their utilization (Bolling, 2003). Furthermore, inadequate information dissemination regarding the requirements of the laws (e.g., appropriate locations for abandonment, time limits) may result in mothers leaving their infants in undesignated locations, outside of compliance with the state law (Bolling, 2003). To date, 15 states mandate public information campaigns to increase public awareness of safe haven legislation (Pollock

& Hittle, 2003). Several common elements of such campaigns include toll-free hotlines, pamphlets and written material, and public service messages. Implementation of these efforts, however, is limited as only three states provide funding for these services (Pollock & Hittle, 2003).

In addition, some issues have been raised regarding the implementation of these laws. For example, allowing a mother to leave an infant anonymously may not protect a father's parental rights (Bolling, 2003). In addition, many of the safe haven laws do not require the person relinquishing the infant to provide a medical history, which could affect the adoption of these children and their long-term health (American Adoption Congress, 2001; Dailard, 2000; Pollock & Hittle, 2003). Furthermore, concern has been raised over potential conflicts of safe haven laws with existing termination of parental rights (TPR) proceedings as designated by the Child Abuse Prevention and Treatment Act and the Adoption and Safe Families Act (Pollock & Hittle, 2003). While safe haven laws aim to protect abandoned infants, existing laws such as the Indian Child Welfare Act, which gives jurisdiction over child custody to American Indian tribes, must also be considered (Pollock & Hittle, 2003). Finally, Pollock & Hittle (2003) suggest that safe haven laws serve to only address one facet of the discarded infants problem; broader issues, such as pregnancy prevention and improved communication among youth, families, and communities must also be considered.

Conclusion

The boarder and abandoned baby problem has not subsided, nor have the issues of substance use among pregnant women or HIV/AIDS. The problem may have even intensified, with an increase in the number of boarder and abandoned infants and a wider distribution of the problem. Newly affected communities will need to develop innovative ways of addressing their emerging boarder baby and abandoned infant problem. However, the overall decrease in the median length of hospitalization indicates success across systems in expediting permanence for children. Further, in communities where AIA programs exist, there has been considerable success in preventing abandonment and improving the lives of these children and their families.

Identification of women who are at greatest risk for discarding their infants remains a difficult task. Our understanding of these mothers, their motivations, and their circumstances is extremely limited, making intervention a challenge. At present, public education about resources available to pregnant women and alternatives to discarding an infant remains the primary method for addressing this issue. In view of the lack of information, efforts to collect data about the circumstances and characteristics of parents who discard their infants, and tracking the experiences of discarded infants and those dropped off in safe havens are critical to addressing this problem.

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