New York City Council's Committees on Hospitals, Health, and Women and Gender Equity

Oversight Hearing re: Maternal Mortality and Morbidity in New York City

December 7, 2020

Joint Written Testimony of Ancient Song Doula Services, The Bronx Defenders, Movement for Family Power, National Advocates for Pregnant Women, and the New York Civil Liberties Union

We are grateful to the City Council Committees on Hospitals, Health, and Women and Gender Equity for the opportunity to submit the following testimony. Ancient Song Doula Services,[1] The Bronx Defenders,[2] Movement for Family Power,[3] National Advocates for Pregnant

[1] Ancient Song Doula Services is an international doula certifying organization with the goal to offer quality Doula Services to Women of Color and Low Income Families who otherwise would not be able to afford Doula Care, and training a workforce of full spectrum doulas to address health inequities within the communities they want to serve. Ancient Song Doula Services mission is to offer all pregnant and parenting individuals regardless of their socio-economic standing quality Doula Care, provide resources young mothers to make healthy choices in their lives, and advocacy to address health inequities within marginalized communities.

[2] BxD is a public defender non-profit that is radically transforming how low-income people in the Bronx are represented in the legal system, and, in doing so, is transforming the system itself. BxD seeks thoughtful, creative, energetic individuals with a strong commitment to social justice to join our dynamic and diverse staff. Our staff of over 350 includes interdisciplinary teams made up of criminal, civil, immigration, and family defense attorneys, as well as social workers, benefits specialists, legal advocates, parent advocates, investigators, and team administrators, who collaborate to provide holistic advocacy to address the causes and consequences of legal system involvement. Through this integrated team-based structure, we have pioneered a groundbreaking, nationally-recognized model of representation called holistic defense that achieves better outcomes for our clients.

[3] Movement for Family Power works to end the Foster System's policing and punishing of families in order to create a world where the dignity and integrity of all families is valued and supported. Rooted in

Women,[4] and the New York Civil Liberties Union[5] submit this collective testimony to lend our strong support to your work to improve maternal and child health outcomes and better the lives of families and communities. We are a coalition of advocacy and defense organizations that work collaboratively to eliminate discrimination at the intersection of reproductive health and child welfare. Our testimony highlights the often unexplored, yet critical connection between discriminatory drug testing in health care settings and involvement by the family regulation system,[6] the resulting harms of family separation, and the deleterious consequences for maternal and infant health and well-being. Improving maternal health outcomes requires eliminating structural discrimination and medical racism. We need courage and holistic approaches to undo and heal the stigma and violence perpetuated by this country's history of racism, classism, patriarchy and ableism. We applaud you for lifting up the voices of impacted families and birth justice advocates to find solutions, and we hope to add this necessary piece of the conversation in support of a robust dialogue around maternal health. We urge you to explore bold and creative solutions that ensure care during and following birth is non-discriminatory, culturally responsive, respectful, supportive, and patient-informed.

The United States' History of Drug Use, Racism and Black Mothers

In the 1980s and 90s, increased media attention on women who used crack-cocaine perpetuated a racist narrative.[7] During the so-called "crack epidemic," the media, researchers and policymakers aggressively advanced a narrative that women and people of color were

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abolitionist principles and our elders, driven by movement lawyering, impacted people MFP carries out its work by: (1) Building out a loving, healthy community with and amongst people working to shrink the Foster System: (2) Raising social consciousness around the harms of the foster system to support the reclaiming and reimagining of Safe and Healthy Families; and (3) Disrupting and curtailing Foster System Pipelines, reducing the level of harm inflicted by forced family separations.

[4] NAPW works to secure the human and civil rights, health and welfare of all people, focusing particularly on pregnant and parenting people, and those who are most likely to be targeted for state control and punishment — low income women, women of color, and drug-using women.

[5] The NYCLU, the New York State affiliate of the American Civil Liberties Union, is a not-for-profit, nonpartisan organization that defends and promotes the fundamental principles and values embodied in the Bill of Rights, the U.S. Constitution, and the New York Constitution through an integrated program of litigation, legislative advocacy, public education, and community organizing.

[6] Many, including scholar Professor Dorothy Roberts, have come to refer to the so-called "child welfare" system as the family regulation system, given the harms historically and currently perpetuated by the system. *See e.g.*, Dorothy Roberts, "Abolishing Policing Also Means Abolishing Family Regulation", The Imprint (June 16, 2020), *found at*: https://imprintnews.org/child-welfare-2/abolishing-policing-also-means-abolishing-family-regulation/44480.

[7] *See e.g.*, Michael Winerip, "Revisiting the 'Crack Babies' Epidemic That Was Not," New York Times, May 20, 2013, *found at***:** https://www.nytimes.com/2013/05/20/booming/revisiting-the-crack-babies-epidemic-that-was-not.html; New York Times Editorial "Board, Slandering the Unborn," New York Times, Dec. 28, 2018, *found at* https://www.nytimes.com/interactive/2018/12/28/opinion/crack-babies-racism.html (An apology from the New York Times explaining "how bad science and a moral panic [about pregnant women and crack], fueled in part by the news media, demonized mothers and defamed a generation").

more likely to be associated with crack use, and responded with punitive measures.[8] With this increased scrutiny and punishment, the reproductive rights and caregiver roles of women who use drugs became a major subject of political debate. The War on Drugs further entrenched this country's history of reproductive coercion and violence, which was largely against enslaved Black women, Latinxs, Indigenous women and women of color, by reinforcing notions of who is and who is not deserving of motherhood.

It was a perfect storm. As a result of the War on Drugs, the population of parents and children under foster system supervision and control increased sharply.[9] Hospitals were drug testing Black and Latinx mothers at birth largely based on a grossly exaggerated "crack baby" mythology. At the same time, the federal government began to pour unprecedented funds into reimbursing states for the costs of removing children from their mothers (with no comparable funding increase for reunification), while simultaneously decreasing funds for basic necessities for families such as health care – including mental health and drug treatment – housing or child care.[10]

Law and Policy: Federal Child Abuse Prevention and Treatment Act (CAPTA)

While the panic surrounding crack-cocaine use has abated (and indeed was found to be unsupported by medical research and science),[11] the policies and practices created during this era continue to inform how reproductive health care is administered and regulated for people who use drugs. One such example is the rapid expansion of state laws surveilling pregnant people expanded in response to the Child Abuse Prevention and Treatment Act (CAPTA), and the Comprehensive Addiction and Recovery Act (CARA).[12]

Enacted in 1974, CAPTA provides federal funding to states to support the "prevention, assessment, investigation, prosecution, and treatment" of child abuse, in exchange for states' fulfillment of certain requirements. In the last twenty years, CAPTA has been amended to require states to have policies in place to "notify" child welfare agencies of babies who fall into one of the three categories: being "affected by substance abuse," affected by "withdrawal

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[8] *See e.g.*, *Ferguson v. City of Charleston*, 532 U.S. 67 (2001); *Ferguson v. City of Charleston*, 308 F.3d 380 (4th Cir. 2002) (finding that policy directed to primarily Black pregnant patients authorizing searches for evidence of drug use in the guise of medical testing violated the 4th Amendment's prohibition on searches without consent or warrants).

[9] Leroy Pelton, For Reason of Poverty: A Critical Analysis of the Public Child Welfare System in the United States (1989), pp. 6–7, 10–13; Dorothy Roberts, Shattered Bonds, 2002, pp. 174-177; National Coalition for Child Protection Reform, A Child Welfare Timeline, *found at***:** https://nccpr.org/a-child-welfare-timeline/.

[10] *Id*.

[11] Increased research on the impact of cocaine exposure on developing fetuses revealed that the impact of the substance was exaggerated and largely decontextualized. *See e.g.*, Kristina B. Wolff, Panic in the ER: Maternal Drug Use, the Right to Bodily Integrity, Privacy, and Informed Consent, Politics & Policy, vol. 39, no. 5, (Oct. 2011) pp. 679–714, *found at*: https://onlinelibrary.wiley.com/doi/abs/10.1111/j.1747-1346.2011.00313.x.

[12] 42 U.S.C. § 5106; U.S. Dep't of Health and Human Services, Admin. For Children and Families, About CAPTA: Legislative History (July 2011), *found at***:** https://www.childwelfare.gov/pubPDFs/about.pdf.

symptoms resulting from prenatal drug exposure," or having Fetal Alcohol Spectrum Disorder.[13] These notifications neither legally require child protective reports, nor require hospitals to drug test pregnant people, people who give birth, or newborns. Nevertheless, studies confirm that doctors and hospitals frequently misunderstand their responsibility under CAPTA. Moreover, states have widely expanded the scope of legal requirements to further consecrate the practice of routine and medically unnecessary drug testing and reporting in hospital settings.[14]

The Womb-to-Foster-Care Pipeline

Through this process, our health care system transformed into a tool to expand the family regulation system, paving a "womb-to-foster-care" pipeline.[15] A primary way that pregnant people and new parents come to the attention of child welfare authorities is through prenatal and postpartum care providers when people, particularly low-income Black and Latinx women, give birth and are drug tested without notice or their consent. There is often no medical explanation or reason given or recorded in the medical record for why the test was deemed necessary, nor is there consensus that such tests are ever medically necessary. Nevertheless, and despite the absence of any indicators of harm or risk of harm to the newborn, hospitals conduct these tests and routinely report positive toxicology results to the Office of Children and Family Services' (OCFS) Statewide Central Register of Child Abuse and Maltreatment (SCR), exposing families to unnecessary government intervention, and in some cases, family separation.[16]

The punitive aspects of our current reporting practices result in family separation and threaten the health and wellbeing of both mothers and newborns. Indeed, the American College of Obstetricians and Gynecologists (ACOG) opposes nonconsensual drug testing and

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[13] *Id*.

[14] *E.g*. Lloyd, et al., The Policy to Practice Gap: Factors Associated with Practitioner Knowledge of CAPTA 2010 Mandates for Identifying and Intervening in Cases of Prenatal Alcohol and Drug Exposure, The Journal of Contemporary Social Services, Vol 99(3), (2018) pp. 232-243, *found at*: https://doi.org/10.1177/1044389418785326.

[15] For more information on the womb-to-foster-care pipeline, see Emma Ketteringham, et al., Healthy Mothers, Healthy Babies: A Reproductive Justice Response to the Womb to Foster Care Pipeline, 20 CUNY L. Rev. 77 (2016). Much like "school-to-prison" pipeline, a term used to describe the ways in which marginalized and at-risk school children are pushed out of the public education system into the juvenile and criminal justice systems, the womb-to-foster-care pipeline refers to the policies and practices of the current family regulation system that push impoverished newborns, especially babies born to system-involved families, who are predominantly low-income and of color, out of the womb and into the foster care system. This pipeline reflects the systemic inequality within which the child protection system operates and the disregard for the critical bond between a newborn and its childbearing parent. The fear of having one's newborn taken often causes system-involved pregnant women to not access prenatal care and seek essential services, ultimately making them even more vulnerable to family disruption and other adverse effects.

[16] Movement for Family Power, et al, Family Separation in the Medical Setting: The Need for Informed Consent, Nov. 2019, *found at*: https://static1.squarespace.com/static/5be5ed0fd274cb7c8a5d0cba/t/5e6ac6f3ea60e51301d4ee47/1584056066082/Policy+Brief+2020.pdf.

responding to drug use during pregnancy with punitive measures such as criminal prosecution or the threat of child removal:

> Seeking obstetric–gynecologic care should not expose a woman to criminal or civil penalties, such as incarceration, involuntary commitment, loss of custody of her children, or loss of housing. These approaches treat addiction as a moral failing. Addiction is a chronic, relapsing biological and behavioral disorder with genetic components. The disease of substance addiction is subject to medical and behavioral management in the same fashion as hypertension and diabetes. Substance abuse reporting during pregnancy may dissuade women from seeking prenatal care and may unjustly single out the most vulnerable, particularly women with low incomes and women of color. Although the type of drug may differ, individuals from all races and socioeconomic strata have similar rates of substance abuse and addiction.[17]

Similarly, in a recent position statement, the National Perinatal Association warned that treating perinatal substance abuse "as a deficiency in parenting that warrants child welfare intervention" has many risks, including the consequence of "pregnant and parenting people avoiding prenatal and obstetric care and putting the health of themselves and their infants at increased risk."[18] As they put it, the "threats of discrimination, incarceration, loss of parental rights, and loss of personal autonomy are powerful deterrents to seeking appropriate prenatal care."[19]

Although testing of pregnant people and newborns for the presence of licit and illicit substances is, in theory, intended to promote public health, these medical expert perspectives make clear the existence of the attendant risks of such testing. Further, we know, and the medical experts attest, that this practice creates barriers to obtaining maternal health care and too often results in traumatic and stressful family separation. Efforts to protect children from harm have expanded the surveillance responsibilities of actors who come into contact with families, such as health care workers and social workers, and perversely and needlessly exposed the most under-resourced and vulnerable families to unnecessary family separation and the disruption of maternal-infant bonding. The expansion of reporting obligations into the realm of reproductive health care makes seeking care a precarious endeavor by traumatically interrupting access to health care. When pregnant people and new parents are tested and reported to child welfare authorities their relationship with medical providers is damaged (and

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[17] American College of Obstetricians and Gynecologists Committee on Health Care for Underserved Women, Committee Opinion 473, Substance Abuse Reporting and Pregnancy: The Role of the Obstetrician-Gynecologist (2011, reaffirmed 2014).

[18] National Perinatal Association, Position Statement, Perinatal Substance Use (2017).

[19] *Id.*; *See also* Shelly Gehshan, Southern Reg'l Project on Infant Mortality, *A Step Toward Recovery: Improving Access to Substance Abuse Treatment for Pregnant and Parenting Women* ii, 5 (1993); Steven J. Ondersma *et al.*, *Prenatal Drug Exposure and Social Policy: The Search for an Appropriate Response*, 5 *Child Maltreatment* 93, 99 (2000) ("[B]ringing high levels of coercion to bear on parents increases the likelihood that contact with outside agencies and hospitals will be avoided by pregnant mothers.").

in some cases severed), and future engagement with providers drops precipitously.[20] As a result of existing policies and practices, rather than access to health care from trusted providers, families are subjected to surveillance and regulation by child welfare authorities and courts.

Reporting patients to child welfare authorities rather than offering them assistance or care for disclosures such as prior or current mental health diagnoses, current or prior substance use, food insecurity, housing instability, and/or intimate partner violence, effectively turns patients' care teams against them. Because patients believe that these disclosures systematically trigger calls to the authorities, rather than compassionate care and the provision of services, patients censor themselves and cannot build trusting provider-patient relationships. A report made to the child welfare authorities leads to an invasive state investigation of a parent's most personal details and family life, often beginning with calls and visits to a birthing parent's bedside right after giving birth, and continuing with visits to a family's home, the homes of other family members, and interrogations of neighbors, teachers, and children. Such an investigation can then lead to court involvement where – even absent a removal of a child – a family will be subjected to unannounced home visits and all-pervasive surveillance for months if not years. When a patient cannot be honest with their health care provider, they cannot receive the care and support they or their families need.[21]

Removals of Children Cause Life-Long Trauma for Children and Families

Further, while the science on the harms caused by prenatal exposure to drugs is, at best, inconclusive,[22] decades of scientific studies make one harm unambiguously clear: Unnecessary, forced family separation, especially among newborns, causes long-term trauma for children and families. As the Federal Government's Children's Bureau Child Welfare Information Gateway emphasizes, "[r]emoving children from their families is disruptive and traumatic and can have long-lasting, negative effects."[23] The harm of family separation cannot be underestimated; the trauma produced by family separation is long lasting and reverberates across generations and communities. In particular, the first few moments, days, and weeks of an infant's life contain critical developmental stages, which can have lifelong repercussions. These critical stages impact attachment, development, and a child's ultimate sense of security.

For example, studies in the context of prison nurseries have observed that "[p]rison nurseries [eliminate] separation created by maternal incarceration as a threat to a child's development,

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[20] Laura Faherty, et al., Association of Punitive and Reporting State Policies Related to Substance Use in Pregnancy With Rates of Neonatal Abstinence Syndrome, JAMA (Nov. 13, 2019), *found at*: https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2755304.

[21] *See e.g.*, Emma Ketteringham, et al., Testimony before the New York City Council Committee on General Welfare jointly with the Committee on Hospitals (Jan, 21, 2020).

[22] *See*, *e.g.*, *supra* footnote 8.

[23] U.S. Children's Bureau, In-Home Services in Child Welfare, March 2014, *found at*: https://www.childwelfare.gov/pubPDFs/inhome_services.pdf.

at least during early infancy."[24] Separation may damage developing attachment, thus increasing the likelihood of poor developmental outcomes.[25] The benefits of keeping mothers and babies together is also demonstrated in numerous studies documenting the value of "rooming in." Scientific research establishes that "rooming-in"—keeping new mothers and newborns together immediately after birth—reduces the transitory and treatable effects that sometimes occur as a result of prenatal exposure to opioids and the recommended medications for treating opioid dependency.[26]

The research confirms the intuitive point that children do better when they remain with their parent(s) at birth, when they can first develop secure attachments. Indeed, studies further reveal that even for children on the margin of foster care placement who live in homes with identifiable risks, children who remain home with their families, with supports in place, are more likely to have more positive life outcomes than if they were removed.[27] Placement in the foster system and subsequent placement changes affect children's ability to build healthy attachments and has negative effects on their quality of life long term.[28] Research shows that many children exit the foster system facing a host of negative life circumstances and outcomes.[29] Indeed, one recent study found that by age twenty-four, 16 percent of young men who had aged out of the foster system were incarcerated and nearly three-fifths had been

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[24] L.S. Goshin, et al., Preschool outcomes of children who lived as infants in a prison nursery, 94 The Prison Journal 139–158 (2014), *found at*: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2942021/.

[25] *Id*. One study found that "[c]hildren who spent time with their mother in a prison nursery had significantly lower mean anxious/depressed and withdrawn behavior scores than children who were separated from their mother in infancy or toddlerhood because of incarceration" and that "[i]n contrast, separation due to early maternal incarceration is associated with much higher rates of insecure attachment to both the mother and alternate caregiver."

[26] *See*, *e.g.*, Kathryn Dee L. MacMillan, MD, et. al., Association of Rooming-in With Outcomes for Neonatal Abstinence Syndrome, A Systematic Review and Meta-analysis, JAMA Pediatr. 2018, *found at*: https://jamanetwork.com/journals/jamapediatrics/fullarticle/2672042; Matthew R. Grossman, MD, et. al, An Initiative to Improve the Quality of Care of Infants with Neonatal Abstinence Syndrome, Pediatrics May 2017, e20163360, *found at*: http://pediatrics.aappublications.org/content/early/2017/05/16/peds.2016-3360.

[27] Joseph J. Doyle, Jr., Child Protection and Child Outcomes: Measuring the Effects of Foster Care, 97 Am. Econ. Rev. 1583, 1584 (2007) (comparing young adults who had been in foster care to a group of adults who had been similarly neglected but remained with their families and finding that, compared to the group who stayed with their birth families, those placed in foster care were more likely to be arrested).

[28] For a summary of this research, *see* Vivek Sankaran and Christopher Church, Easy Come, Easy Go: The Plight of Children Who Spend Less Than Thirty Days in Foster Care, 19 U. Pa. J.L. & Soc. Change 207 (2017).

[29] *See e.g.*, Catherine R. Lawrence et al., The Impact of Foster Care on Development, 18 Dev. & Psychopathology 57 (2006); K. Chase Tovall & Mary Dozier, Infants in Foster Care: An Attachment Theory Perspective, 2 Adoption Q. 55 (1998); U.S. Gov't Accountability Office, GAI-12-270T, Foster Children: HHS Guidance Could Help States Improve Oversight of Psychotropic Prescriptions, (2011); Patrick J. Fowler et al., Pathways to and From Homelessness and Associated Psychosocial Outcomes Among Adolescents Leave the Foster Care System, 99 Am. J. Pub. Health 1453 (2009).

convicted of a crime since age 18.[30] Surveys have found that nearly one third of homeless youth and well over half of victims of child trafficking had experience in the foster system.[31]

These harmful impacts cannot be overstated. Moreover, we know the system is inherently biased and discriminatory. Health care providers are charged with deciding when to test, who to test, and who to report to the authorities. This selective drug-testing of pregnant or postpartum people and newborns necessarily carries the service provider's bias about the subject of the testing. Similar to stop and frisk practices, the "test and report" practice of hospitals and child welfare authorities reveal extreme racial disparities. Studies clearly bear this out. For instance, where urine toxicology results were anonymously collected over a 6-month period, it was found that despite similar rates of substance use among Black and white women in the study, Black women were reported to social services at approximately 10 times the rate for white women, and low-income women were more likely than others to be reported.[32]

Consistent with trends in the racial disparities that plague the family regulation system at large, poor Black and Latinx pregnant people and their newborns are dramatically and disproportionately targeted by hospitals for drug tests, regardless of whether they meet hospital guidelines for testing. Setting aside the discrepancies in applying screening criteria that exist regardless of race, evidence suggests that criteria calling for drug testing to be performed, "seemed to be selectively ignored by providers more frequently for infants born to white women."[33] Further bolstering the findings of various academic studies on this issue, the New York Daily News conducted a survey and found that "[p]rivate hospitals in rich neighborhoods rarely test new mothers for drugs, whereas hospitals serving primarily low-income moms make those tests routine and sometimes mandatory."[34] These types of dynamics are present across New York State.

Hospital practices that target low-income Black and Latinx people for nonconsensual, often surreptitious drug tests cannot be justified by claims that Black and Latinx pregnant people use drugs at higher rates than white pregnant people. It is well-documented that Black people

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[30] Jennifer L. Hook & Mark E. Courtney, Employment of Former Foster Youth as Young Adults: Evidence from the Midwest Study, (2010).

[31] *See e.g.*, Chapin Hall and Voices of Youth Count, Missed Opportunities: Youth Homelessness in America, Nov. 2017; Debra S. Wolfe, et al., Human Trafficking Prevalence and Child Welfare Risk Factors Among Homeless Youth (Jan. 2018), *found at*: https://fieldcenteratpenn.org/wp-content/uploads/2013/05/6230-R10-Field-Center-Full-Report-Web.pdf.

[32] Ira Chasnoff, et al., The Prevalence of Illicit-Drug or Alcohol Use during Pregnancy and Discrepancies in Mandatory Reporting in Pinellas County, Florida, New England Journal of Medicine, 2019, *found at*: https://www.nejm.org/doi/full/10.1056/NEJM199004263221706.

[33] Ariadna Forray, Substance use during pregnancy, 5: F1000 Faculty Rev-887 (2016), *found at*: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4870985/; *see also*, Linda Fentiman, Blaming Mothers: American Law and the Risks to Children's Health (N.Y.U. Press 2017).

[34] Oren Yaniv, "WEED OUT: More than a dozen city maternity wards regularly test new moms for marijuana and other drugs," NY Daily News (Dec. 29, 2019), *found at*: https://www.nydailynews.com/new-york/weed-dozen-city-maternity-wards-regularly-test-new-mothers-marijuana-drugs-article-1.1227292#ixzz31hXS2sUE.

use illicit substances at rates no higher than any other race.[35] Similarly, studies have specifically found that Black and Latinx pregnant people use illicit substances at virtually the same rate as white pregnant people.[36] On the other hand, when it comes to prenatal use of cigarettes and alcohol, studies show that white pregnant people actually use these legal substances at greater rates than Black and Latinx pregnant people, despite enjoying much lower rates of nonconsensual tests, reports, court filings, and family separation.[37] This is worth noting because the effects on newborns of criminalized substances, including cocaine and marijuana, are inconclusive, and have been historically presumed and overstated due to the racist legacy of the War on Drugs.[38]

This testing is not required by state or federal law. In New York evidence of a positive toxicology alone is not enough to substantiate a finding of child abuse or neglect. Rather, in addition to a positive toxicology, New York requires there to be evidence suggesting actual harm done to a child.[39] So while state and federal laws do not mandate that hospitals test a pregnant person or their newborn or call in a subsequent test reporting that parent of suspected maltreatment, this does not prevent hospitals from creating their own internal policies and practices governing drug testing of expectant mothers. And while some systems, such as NYC's public hospital system, are beginning to acknowledge the damage caused by nonconsensual drug testing and family separation,[40] we need statutory solutions that apply to all New Yorkers regardless of hospital setting.

Policy Solutions to Prevent Discriminatory Testing Practices and Harmful Family Separation

We applaud you for advancing legislation and resolutions that increase transparency, connect pregnant people to support resources, and improve access to community-based options for

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[35] National Drug Policy Alliance, Race and the Drug War Factsheet.

[36] *See e.g.*, Barry M. Lester, et al., Substance Use During Pregnancy: Time for Policy to Catch Up with Research, Harm Reduction J., Apr. 20, 2004, at 33.

[37] *See e.g.*, Guttmacher Report on Public Policy, State Responses to Substance Abuse Among Pregnant Women, Vol. 3, No. 6 (Dec. 2000).

[38] *See, e.g.,* Deborah A. Frank *et al.*, *Growth, Development, and Behavior in Early Childhood Following Prenatal Cocaine Exposure*, 285 *JAMA* 1613 (2001); Ciara A. Torres, et. Al, *Totality of the Evidence Suggests Prenatal Cannabis Exposure Does Not Lead to Cognitive Impairments: A Systematic and Critical Review*, 11 Frontiers in Psychology 1 (May 2020).

[39] Child Welfare Info. Gateway, Parental Drug Use as Child Abuse (2015); *See also*, *Nassau Cnty. Dep't of Soc. Servs. ex rel. Dante M. v. Denise J.*, 87 N.Y.2d 73, 79 (1995). Courts have explained that absent additional facts concerning the alleged drug use—the frequency, degree, effects, and circumstances of use—the Court cannot assess the impact on the respondent's standard of care in parenting, or whether a child has been harmed or is at risk of harm because of the alleged drug use. *Id*. at 78 (citing Family Court Act 1012(f)(i)(B)); *see, e.g.*, *In re Anastasia G.*, 861 N.Y.S.2d 126, 127–28 (2d Dep't 2008) (admission of past drug use held insufficient to establish neglect where "no evidence was elicited as to the type of drugs the father used, the duration, frequency, or repetitiveness of his drug use, or whether he was ever under the influence . . . while in the presence of the . . . child."

[40] Yasmeen Khan, NYC Will End Practice of Drug Testing Pregnant Patients Without Written Consent, The Gothamist, Nov. 17, 2020, *found at*: https://gothamist.com/news/nyc-will-end-practice-drug-testing-pregnant-patients-without-written-consent.

birth, including those under consideration today: Int 2017-2020 (bill requiring the Department of Health and Mental Hygiene to develop voluntary guidelines for hospital visitation policies in the event of a public health emergency); Int 2042-2020 (bill requiring DOHMH to post information about licensed midwives, including the services they offer and how to find them, on the DOHMH website); Res 1239-2020 (resolution calling on the New York State Legislature to pass legislation making doulas more accessible to individuals with Medicaid and those without health insurance); and Res 1408-2020 (resolution calling on the New York State Legislature to pass legislation relating to accreditation, approval, and operation of midwifery birth centers).

In addition to these measures, and to inform your future policy considerations, our groups bring to your attention recent changes on the city level with respect to drug testing.

For many years, people personally impacted by the family regulation system and advocates working with them have shed light on how hospitals' "test and report" practice is rooted in racism and classism, unsupported by medical science, and results in harmful and traumatic family separation. In response to this sustained advocacy, NYC Health and Hospitals Corporation (HHC) recently promulgated a new drug testing and informed consent policy, requiring that absent emergency circumstances, all HHC medical providers must obtain written informed consent before subjecting a pregnant person to a toxicology test, among other things. Additionally, ACS and the NYC Department of Health (NYC DOH) issued a new policy clarifying health care providers' obligations under CAPTA. Although both policies recognize that substance use disorder is a medical condition and not a moral failing, and reflect steps in the right direction, both policies fall short of ending the harmful practice of "test and report" and fail to disentangle health care from policing systems like the family regulation system.

With respect to HHC's new drug testing and screening policy, strikingly the policy is silent on newborns. Specifically, nothing in HHC's new policy stops public hospitals from drug testing newborns without parental consent. That practice is equally as harmful as testing pregnant and perinatal people without informed consent, undermining parents' trust in their medical providers and putting familial integrity at risk. Many parents have shared with us that just as targeting pregnant people for nonconsensual drug tests causes fear and mistrust of healthcare providers, so too (and perhaps even more so) does medical providers targeting their newborns. As such, HHC's drug testing and screening policy leaves firmly in place the pipeline that currently flows from hospitals to the family regulation system. What is more, leaving undisturbed the routine practice of testing newborns without parental consent compounds the stigma that already exists around substance use and sends an implicit message to Black, Latinx, Indigenous, and low-income parents that their children's healthcare providers don't trust them.

Additionally, HHC's shift to universal screening (as opposed to testing) is not a panacea. Without seriously interrogating the racism, classism, patriarchy, and ableism entrenched in our healthcare system, hospitals will continue to reproduce racial disparities and inequities that exist in maternal fetal healthcare. Indeed, studies show that even with universal

screening, Black women are four times more likely to be reported to CPS than white women.[41] Moreover, screening without a guarantee that pregnant and newly parenting people will have access to the care they need, including substance use disorder treatment, and will not face punitive consequences, does not further maternal fetal health. Indeed, this practice may further undermine it.[42] Before developing and implementing screening tools, HHC and other health care providers should focus time, energy, and resources on breaking healthcare providers' dependence on CPS, and cultivating relationships with non-punitive, community-based supports.

While we are encouraged by HHC's change in policy, we hope that HHC engages in an open and transparent conversation with the public about how it intends to implement and track whether the policy is indeed being followed by HHC staff. We know that, despite HHC having previously promulgated a drug testing informed consent policy in 2014, it was ignored by HHC health care providers, and pregnant people and their newborns were routinely subjected to drug tests without their knowledge and consent. Transparency is one of the cornerstones of building trust. Among other things, HHC should make publicly available de-identified data regarding the number of pregnant people, perinatal people, and newborns it drug tests, disaggregated by race, ethnicity, zip code, and HHC hospital. HHC should also make publicly available de-identified data regarding the number of pregnant people, perinatal people, and newborns who returned a positive toxicology, and were subsequently reported to ACS, disaggregated by race, ethnicity, zip code, and HHC hospital. This data should include the aggregate cost of the drug tests performed on pregnant patients, new parents and newborns.

Finally, with respect to ACS and NYC DOH's policy clarifying healthcare providers' duties and obligations under CAPTA, we are encouraged that the policy embraces what has been the law in New York for many years—that a positive toxicology alone is not sufficient to warrant a report to the SCR—and encourages providers to consider how their own biases inform their decisions on who to report to the SCR. These are good things. It is concerning, however, that the policy conflates and commingles requirements under CAPTA with New York State mandated reporter requirements. To be clear, no provision in CAPTA requires health care providers to make reports to CPS, even if the provider determines that the infant is born affected by substance use.[43] Moreover, nothing in CAPTA requires involving CPS when working with families to create a plan of safe care. New York State mandated reporter laws, which are separate and apart from CAPTA, only require a report to the SCR where the mandated reporter has reasonable cause to suspect that a parent for a child has abused or

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[41] *See* Sarah C. M. Roberts & Amani Nuru-Jeter, Universal screening for alcohol and drug use and racial disparities in Child Protective Services reporting, J Behav Health Serv Res. 2012 January; 39(1): 3–16, available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3297420/.

[42] Some have suggested that, "[a]s with any screen, a screen for unhealthy drug use should only be performed when clinical management can be effectively tailored in response to a positive screen result." Arthur Robin Williams, et al., The Perils of Screening for Unhealthy Drug Use Are a Call to Action for the Mental Health Workforce. Nov. 2020; JAMA Psychiatry 77(11), 1101.

[43] Understanding CAPTA and State Obligations, National Advocates for Pregnant Women 2 (Oct. 2020), available at https://mk0nationaladvoq87fj.kinstacdn.com/wp-content/uploads/2020/11/2020-revision-CAPTA-requirements-for-states-10-29-20-1-1.pdf.

maltreated that child. Yet, under certain circumstances in which an infant is born affected by substance use, the ACS/NYC DOH policy erases the requirement that the mandated reporter have reasonable cause to suspect child abuse or maltreatment, and directs the provider to make a report to the SCR. Neither CAPTA nor New York State mandated reporter laws require such reporting, absent reasonable cause to suspect that a parent has abused or maltreated the child. The ACS/DOH policy reinforces the unsupported and dangerously faulty notion that drug use or having a substance use disorder are predictive or determinative of parenting ability.

In pursuit of improving maternal health outcomes, we urge you to give attention to the urgent issue of drug testing, family separation, racial disparities, and harmful health outcomes. In October of 2019, the Committee on General Welfare conducted a hearing on a package of measures concerning child welfare, the due process rights of parents and families, and ACS (Intros. 1715-2019, 1716-2019, 1717-2019, 1718-2019, 1719-2019, 1727-2019, 1728-2019, 1736-2019, and 1426-2019). While advocates at the hearing noted that several of the bills under consideration should be revisited and revised before they are brought for a vote, that hearing and the pending legislative package served as an entryway into the conversation and an important first step in examining the flaws of the family regulation system at the local level. However, after more than a year, these measures have not been advanced further.

Intro. 1426-2019, a bill laid over in committee, would require comprehensive reporting by ACS on investigations initiated in response to drug test results shared by public hospitals. While advocates have further language recommendations for ensuring the bill is effective, this proposal is critical to helping policymakers better understand the impact and frequency of drug testing, the communities most affected, and whether it unjustifiably results in family separation. Moreover, there are a number of bills in the New York State legislature that seek to limit or reduce the number of children who enter the foster system by ensuring parents have access to support and information and can make informed decisions for themselves and their children. The passage of these reform bills is an important step in addressing the racial disparities in New York's family regulation system, and we urge your committees to understand and work with your state colleagues to support these measures.

Critical to our conversation here, and considering the legal ramifications of a positive toxicology or assessment, it's imperative that patients be made aware of the health benefits as well as the legal consequences of submitting to a drug test, and be allowed to make informed decisions about their medical care. To this end, we strongly support A.5478A, a state bill that would require prior written informed consent by a pregnant or perinatal person for drug testing of themselves or their newborn child. Demanding that pregnant people and their newborns have, at minimum, a knowledge of, and give written consent to, the drug testing of their own body and children is a discrete but significant step forward in ensuring that all members of our community are treated with dignity and humanity.

While measures at the city and state level are a step forward, we urge your committees to consider these policy changes in order to improve maternal and child health outcomes and better the lives of families and communities.

We look forward to continuing this dialogue with you – thank you for the opportunity to be heard and to make a real difference for families and communities in New York.

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