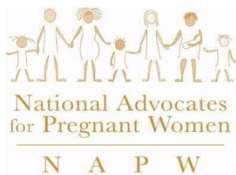




**BROOKLYN
DEFENDER
SERVICES**



**New York State Assembly Health Committee and Assembly Task
Force on Women's Issues**

**Hearing Regarding Improving Maternal and Newborn Health: Access
to and Quality of Perinatal Care**

November 30, 2021

**Joint Written Testimony of Ancient Song Doula Services, Brooklyn
Defender Services, The Bronx Defenders, Drug Policy Alliance, Dr.
Mishka Terplan, Elephant Circle, JMacForFamilies, Movement for
Family Power, National Advocates for Pregnant Women,**

Neighborhood Defender Service of Harlem, and the New York Civil Liberties Union

We are grateful to the Assembly Health Committee, Chair Assembly Member Richard N. Gottfried, and Assembly Task Force on Women's Issues for the opportunity to submit the following testimony. Ancient Song Doula Services,¹ Brooklyn Defender Services,² The Bronx Defenders,³ Drug Policy Alliance,⁴ Dr. Mishka Terplan,⁵ Elephant Circle,⁶ JMacForFamilies,⁷

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 for young mothers to make healthy choices in their lives, and advocacy to address health inequities within marginalized communities.

² Brooklyn Defender Services (BDS) provides multi-disciplinary and people-centered criminal, family, and immigration defense, as well as civil legal services, social work support and advocacy to nearly 30,000 people and their families in Brooklyn every year. In addition to zealous legal defense, we provide a wide range of legal services and advocacy to meet our clients' unique needs. Our expertise lies in the intersection of the criminal legal, immigration, and family regulation systems that disproportionately target low-income communities of color. In many cases, our advocacy is of a preventive nature, helping people maintain or access housing, immigration status, public benefits, education and employment.

³ 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.

⁴ The Drug Policy Alliance is the nation's leading organization working to advance policies and attitudes that best reduce the harms of both drug use and drug prohibition and to promote the sovereignty of individuals over their minds and bodies. We envision a just society in which the use and regulation of drugs are grounded in science, compassion, health, and human rights; in which people are no longer punished for what they put into their own bodies; and in which the fears, prejudices, and punitive prohibitions of today are no more.

⁵ Mishka Terplan is a physician, boarded in both ObGyn and Addiction Medicine, whose clinical, research, advocacy, and public health interests lie along the intersections of reproductive and behavioral health.

⁶ Inspired by elephants who give birth within a circle of support, we envision a world where all people have a circle of support for the entire perinatal period. Elephant Circle brings an intersectional, feminist, reproductive justice, design thinking approach to this work. Our model includes both the HOW and the WHAT of birth justice. How: strategies for tackling systems of power and oppression and strategies for change and resilience. What: expertise in health systems, legal systems and the perinatal period.

⁷ JMacforFamilies is led by a parent impacted and works to end the systemic oppression of families caused by the policing of families under the guise of protection. We are intentionally advocating to increase awareness of the harms caused by the Child Protection System (Family Policing System) during, and after an investigation.

We are assembling people who have experienced the unchecked power of the family policing system to make legislative changes that will keep families together safe, happy, and thriving. We will achieve our goals by (1) Ensuring families "Know their rights and (2) Preventing the weaponization of the family police against families. In addition, we will achieve the goal of transforming the punitive response taken by mandated reporters when a family is experiencing poverty related challenges by empowering mandated reporters to

Movement for Family Power,⁸ National Advocates for Pregnant Women,⁹ Neighborhood Defender Service of Harlem,¹⁰ and the New York Civil Liberties Union¹¹ are submitting this collective testimony to lend our strong support to your work to improve maternal and newborn health outcomes and better the lives of families and communities across New York State. Together we are a coalition of activists, advocates, and advocacy and defense organizations that work collaboratively to eliminate discrimination at the intersection of reproductive health and the family regulation system.¹² Our comments thereby raise the often unexplored, yet critical connection between discriminatory drug testing in health care settings, involvement by the family regulation system that results in harmful family separation, and the deleterious consequences for maternal and infant health and well-being. Improving maternal and newborn 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. This is a necessary piece of any robust dialogue around maternal and newborn health, and we urge this committee to explore bold and creative solutions that ensure perinatal care 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 of women who used crack-cocaine perpetuated a racist narrative.¹³ During this so-called "crack epidemic," the media, researchers and policymakers aggressively advanced a narrative that women and people

support families by referring them to places where they can have their needs met instead of to the family police who only provide surveillance

⁸ 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 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.

⁹ 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.

¹⁰ The Neighborhood Defender Service of Harlem (NDS) is a community-based, client-centered, holistic public defense office located in Harlem, providing criminal, civil, and family court representation to residents of Northern Manhattan who cannot afford to hire a lawyer. NDS clients are represented by multidisciplinary teams including attorneys, advocates, team administrators, investigators and social workers.

¹¹ 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.

¹² 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), <https://imprintnews.org/child-welfare-2/abolishing-policing-also-means-abolishing-family-regulation/44480>.

¹³ See e.g., Michael Winerip, *Revisiting the 'Crack Babies' Epidemic That Was Not*, N.Y. Times, May 20, 2013, <https://www.nytimes.com/2013/05/20/booming/revisiting-the-crack-babies-epidemic-that-was-not.html>.

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

This was a perfect storm. As a result of the War on Drugs, the population of parents and children under the foster system's supervision and control increased sharply.¹⁴ Hospitals were drug testing Black and Latine 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 and child care.¹⁵

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 medicine and science)¹⁶ 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 reinforced and expanded in response to the Child Abuse Prevention and Treatment Act (CAPTA), and the Comprehensive Addiction and Recovery Act (CARA).¹⁷

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 enumerated categories: being "affected by substance abuse," affected by "withdrawal symptoms resulting from prenatal drug exposure" or having Fetal Alcohol Spectrum Disorder.¹⁸ While these notifications neither legally require child protective reports, nor require hospitals to drug test pregnant people, people who give birth, or newborns, studies confirm that doctors and hospitals frequently misunderstand their responsibility under CAPTA, and states have widely expanded the scope of legal requirements to further consecrate the practice of routine and medically unnecessary drug

¹⁴ Leroy Pelton, *For Reason of Poverty: A Critical Analysis of the Public Child Welfare System in the United States* (1989) at 6–7, 10–13; Dorothy Roberts, *Shattered Bonds*, at 174–177 (2002); Nat'l Coalition for Child Protection Reform, *A Child Welfare Timeline*, <https://nccpr.org/a-child-welfare-timeline/>.

¹⁵ *Id.*

¹⁶ 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>.

¹⁷ 42 U.S.C. § 5106; U.S. Dep't of Health and Human Srvs., Admin. for Children and Families, *About CAPTA: Legislative History* (July 2011), <https://www.childwelfare.gov/pubPDFs/about.pdf>.

¹⁸ *Id.*

testing and reporting in hospital settings.¹⁹

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.²⁰ A primary way that pregnant people and new parents come to the attention of family regulation authorities is through prenatal and postpartum care providers when people, particularly low-income Black and Latine 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 and the additional costs associated with drug testing, 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), thus exposing families to unnecessary government intervention, and in some cases, family separation.²¹

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

Clear evidence exists that criminalization and incarceration for substance use disorder during pregnancy are ineffective as behavioral deterrents and harmful to the health of the pregnant person and their infant. Despite the fact that leading medical organizations agree that a positive drug test should not be construed as child abuse or neglect, biologic testing of pregnant people and newborns for the presence of licit and illicit substances is often an institutional policy put in place with the intention of promoting public health. These policies instead use screening

¹⁹ 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) 232-243, <https://doi.org/10.1177/1044389418785326>.

²⁰ 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 system. This pipeline reflects the systemic inequality within which the family regulation 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.

²¹ Movement for Family Power, et al., *Family Separation in the Medical Setting: The Need for Informed Consent*, Nov. 2019, <https://static1.squarespace.com/static/5be5ed0fd274cb7c8a5d0cba/t/5e6ac6f3ea60e51301d4ee47/1584056066082/Policy+Brief+2020.pdf>.

tests as an indicator of child abuse, which results in reporting or referrals to Child Protective Services. This routine practice, sometimes termed “test and report,” disrupts bodily autonomy of the pregnant person and their newborn and is inconsistent with treating substance use disorder as a health condition with social and behavioral dimensions. Before performing any test on the pregnant individual or neonate, including screening for the presence of illicit substances, informed consent should be obtained from the pregnant person or parent. This consent should include the medical indication for the test, information regarding the right to refusal and the possibility of associated consequences for refusal, and discussion of the possible outcome of positive test results. In addition, obstetrician–gynecologists or other obstetric care practitioners should consider patient self-reporting as an alternative, which has been demonstrated repeatedly to be reliable in conditions where there is no motivation to lie, and in clinical settings where there are no negative consequences attached to truthful reporting.²²

Similarly, in a recent position statement, the National Perinatal Association warned that treating perinatal drug use in pregnancy “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.”²³ 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.”²⁴

Although testing of pregnant people and newborns for the presences of licit and illicit substances in theory is 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.²⁵ 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 family regulation authorities

²² Am. Coll. of Obstetricians and Gynecologists, Statement of Policy, *Opposition to Criminalization of Individuals During Pregnancy and the Postpartum Period* (Dec. 2020), found at <https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2020/opposition-to-criminalization-of-individuals-pregnancy-and-postpartum-period> (internal citations omitted).

²³ Nat’l Perinatal Ass’n, Position Statement, Perinatal Substance Use (2017).

²⁴ *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.”).

²⁵ Jamila Perritt, M.D., M.P.H., *#WhiteCoatsForBlackLives — Addressing Physicians’ Complicity in Criminalizing Communities*, New England J. of Medicine (Nov. 5, 2020), https://www.nejm.org/doi/full/10.1056/NEJMp2023305?query=recirc_inIssue_bottom_article.

their relationship with medical providers is damaged (and in some cases severed), and future engagement with providers precipitously drops.²⁶ Critically, the oversight of the family becomes the court’s purview in lieu of treatment and intervention.

These are people whose care team effectively turned against them by reporting patients to family regulation 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. 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 family regulation 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.²⁷

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,²⁸ 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 Children’s Bureau’s Child Welfare Information Gateway emphasizes, “[r]emoving children from their families is disruptive and traumatic and can have long-lasting, negative effects.”²⁹ 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, at least during early infancy.”³⁰ Separation may damage developing

²⁶ 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), <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2755304>.

²⁷ 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).

²⁸ See, e.g., supra footnote 8.

²⁹ U.S. Children’s Bureau, *In-Home Services in Child Welfare*, March 2014, https://www.childwelfare.gov/pubPDFs/inhome_services.pdf.

³⁰ L.S. Goshin, et al., *Preschool outcomes of children who lived as infants in a prison nursery*, 94 *The Prison Journal* 139–158 (2014), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2942021/>.

attachment, thus increasing the likelihood of poor developmental outcomes.³¹ 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 of prenatal exposure to opioids and the associated costs.³²

This 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 placement who live in homes with identifiable risks, those children who remain home with their families, with supports in place, are more likely to have positive life outcomes than if they were removed.³³ Placement in the foster system and subsequent placement changes affect children’s ability to build healthy attachments and have negative effects on their quality of life long term.³⁴ Research shows that many children exit the foster system facing a host of negative life circumstances and outcomes.³⁵ 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 convicted of a crime since age 18.³⁶ 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.³⁷

These harmful impacts cannot be overstated. And what’s more, we know the system is

³¹ *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.”

³² 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 Pediatrics 2018 <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, <http://pediatrics.aappublications.org/content/early/2017/05/16/peds.2016-3360>.

³³ 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).

³⁴ For a summary of this research, see Vivek Sankaran et al., *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).

³⁵ See e.g., Catherine R. Lawrence et al., *The Impact of Foster Care on Development*, 18 Dev. & Psychopathology 57 (2006); K. Chase Tovall et al., *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).

³⁶ Jennifer L. Hook et al., *Employment of Former Foster Youth as Young Adults: Evidence from the Midwest Study* (2010).

³⁷ 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) <https://fieldcenteratpenn.org/wp-content/uploads/2013/05/6230-R10-Field-Center-Full-Report-Web.pdf>.

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 post-partum people and newborns necessarily carries the service provider's bias about the subject of the testing.³⁸ And thus, similar to stop and frisk practices, the "test and report" practice of hospitals and family regulation 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.³⁹

Consistent with trends in the racial disparities that plague the family regulation system at large, poor Black and Latine pregnant people and their newborns are dramatically and disproportionately targeted by hospitals for drug tests, regardless of whether they meet hospital guidelines for testing. Moreover, 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."⁴⁰ 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."⁴¹ These types of dynamics are present across New York State.

Hospitals' practices that target low-income Black and Latine people for non-consensual, often surreptitious drug tests cannot be justified by claims that Black and Latine pregnant people use drugs at higher rates than white pregnant people. It is a well-documented fact that Black people use illicit substances at rates no higher than any other race.⁴² Similarly, studies have specifically found that Black and Latine pregnant people use illicit substances at virtually the same rate as white pregnant people.⁴³ 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 Latine pregnant people, despite enjoying much lower rates of nonconsensual tests, reports, court filings, and family separation.⁴⁴ This is worth noting because the effects on newborns of certain illicit

³⁸ See *supra* note 22.

³⁹ 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>.

⁴⁰ Ariadna Forray, *Substance use during pregnancy* at 5: F1000 Faculty Rev-887 (2016), <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).

⁴¹ 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), <https://www.nydailynews.com/new-york/weed-dozen-city-maternity-wards-regularly-test-new-mothers-marijuana-drugs-article-1.1227292#ixzz31hXS2sUE>.

⁴² Drug Policy Alliance, *Race and the Drug War*, <https://drugpolicy.org/issues/race-and-drug-war>.

⁴³ 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.

⁴⁴ See e.g., Gutmacher Report on Public Policy, *State Responses to Substance Abuse Among Pregnant Women*,

substances, such as cocaine and marijuana, are inconclusive, and have been historically presumed and overstated due to the racist legacy of the War on Drugs.⁴⁵

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 or imminent risk of harm to a child.⁴⁶ 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 pregnant people. And while some systems, such as NYC's public hospital system, are beginning to acknowledge the damage caused by non-consensual drug testing and family separation,⁴⁷ we need statutory solutions that apply to all New Yorkers regardless of hospital setting.

Legislative Measures to Prevent Discriminatory Testing Practices and Harmful Family Separation

For families of color subject to family regulation system investigations, the risk of separation is far greater than for white families. There are a number of bills 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 family regulation system reform bills is an important step in addressing the racial disparities in New York's family regulation system.

Support A.4285 (Rosenthal) / S.4821 (Salazar) to Ensure All Patients Give Written, Informed Consent Before Being Drug Tested and Drug Screened

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.4285/S.4821**, which will require prior written informed consent by a pregnant or perinatal person for drug testing of themselves or their

Vol. 3, No. 6 (Dec. 2000).

⁴⁵ 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).

⁴⁶ Child Welfare Info. Gateway, Parental Drug Use as Child Abuse (2015); see also *Nassau Cty. 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.”

⁴⁷ Yasmeen Khan, *NYC Will End Practice of Drug Testing Pregnant Patients Without Written Consent*, The Gothamist, Nov. 17, 2020, <https://gothamist.com/news/nyc-will-end-practice-drug-testing-pregnant-patients-without-written-consent>.

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 humanity.

Early Access to Legal Assistance During a Family Regulation System Investigation

Having access to legal assistance at the beginning of a family regulation investigation can ensure that parents and caretakers understand the investigation process, result in speedier referrals to important supportive services and help avoid family court filings or unnecessary removals of children.

In February 2018, after conducting an extensive investigation and hearing from many child welfare and Family Court stakeholders, the New York State Commission on Parent Representation issued a report to Chief Judge Janet DiFiore which recommended that parents be “timely provided with relevant information about the right to counsel, and that parents be granted access to counsel during a child protective agency investigation and sufficiently in advance of the first court appearance.”⁴⁸ Even the federal Administration for Children and Families has come out in support of early assignment of counsel: “[t]here is a growing body of empirical research linking early appointment of counsel (at or prior to a party’s initial appearance in court) and effective legal representation in child welfare proceedings to improved case planning, expedited permanency and cost savings to state government.”⁴⁹ Child welfare and legal experts agree: early access to counsel leads to better outcomes for children.

New York’s Family Miranda Bill A.6792 (Walker) / S.5484-A (Brisport) Will Ensure Parents Are Aware of Their Rights During a Family Regulation Investigation

Parents who come into contact with the family regulation system are frequently asked to submit to drug tests during the investigative stage of a case when they have no right to counsel and little support as they navigate these frightening investigations. Case workers often do not advise parents of the specific allegations that led to the investigation leaving parents feeling vulnerable and afraid.

Many parents are routinely asked to submit to drug and alcohol testing even where substance misuse is not an allegation in the investigation. Parents often agree to these invasive tests because they are not told they have a right to refuse, and are fearful of negative consequences, including losing custody of their children. Even if a parent consents to a drug test and the results are negative, that parent’s time, resources, dignity, and right to privacy have been undermined. Parents who do test positive are frequently told that they need to complete a drug treatment program regardless of the substance, history, frequency of use, whether a medical professional has a diagnosed substance use disorder, and without an assessment of whether the parent’s substance use is negatively impacting the children.

⁴⁸ New York State Commission on Parent Representation, *Interim Report to Chief Judge Janet DiFiore*, 16, http://ww2.nycourts.gov/sites/default/files/document/files/2019-02/PLR_Commission-Report.pdf?fbclid=IwAR2DGVUGk86o8SH4HkVij7a9uJyYHWZt7rktZ044xQlnyKH3K9HYNBwqLiw.

⁴⁹ U.S. Dept of Health and Human Srvs., ACYF-CB-IM17-02, Jan. 17, 2017 (citations omitted).

Given the well-documented bias and discrimination within the family regulation system, we strongly support measures that strengthen the rights of those under investigation, including **A.6792/S.5484-A**, a bill requiring family regulation system investigators to inform parents and caretakers of their rights during an investigation. It will ensure that family regulation system investigators retain all the legal authority necessary to protect children, while providing the information and transparency parents need to protect their families from unlawful abuse of that authority. This commonsense bill does not create any new rights, but codifies the uncontroversial idea that parents under state investigation should know their rights before speaking to authorities, rather than being coerced, pressured, or misled by state authorities.

While these measures are a step forward, the Legislature needs to consider other holistic policy changes that will improve maternal and child health outcomes and better the lives of families and communities across New York State. To this end, New York should fund community-based support programs for pregnant people that can mitigate the unnecessary reliance on the family regulation system by health care and other service providers. Along these lines we also support forthcoming legislation that would license Certified Professional Midwives, providers who specialize in community-birth and provide an important alternative to a diverse range of families.

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 State.

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