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Administration for Children's Services

The New York City Council,
Committees on General Welfare and Hospitals
April 10, 2019

"Oversight – Impact of Marijuana Policies on Child Welfare"

Testimony by
David A. Hansell, Commissioner
New York City Administration for Children's Services

Good afternoon Chair Levin, Chair Rivera, and members of the Committees on General Welfare and Hospitals. I am David Hansell, Commissioner of the New York City Administration for Children's Services. With me today is Natalie Marks, Associate Commissioner of Quality Assurance for the Division of Child Protection. We are pleased to join you today to share more about the work ACS is currently doing to protect child safety and promote family well-being, particularly in cases where there have been allegations and/or concerns about substance misuse, including marijuana, as well as the work ahead as we prepare for the possible legalization of marijuana. We are also joined by Dr. Machelle Allen, Senior Vice President and Chief Medical Officer of NYC Health + Hospitals, who is here to answer any questions about Health + Hospitals' policies and practices.

ACS's core mission is to protect and promote the safety and well-being of New York City's children and families. I think we all acknowledge the reality that there are children who experience devastating and tragic neglect while in the care of adults who abuse drugs or alcohol, and it is ACS's responsibility to discern when that danger exists and take action to forestall it. However, in all of our cases, including those with substance misuse allegations, we assess child safety on a case by case basis, looking at actual or potential harm to a child and, if it exists, the parent's capacity to safely care for the child. Current state and city policy (and child welfare best practice) is that the parent's use of a substance – legal or illegal – is not in and of itself a basis for a finding of neglect, much less a child's removal or other court action. As we anticipate the decriminalization of marijuana, these principles must guide our response, and as I will explain, we continually review our practices to ensure that they are consistent with these principles as they are embodied in our policies.

The characterization of marijuana as an illegal substance is under wide review as lawmakers in Albany continue to discuss possible legalization in New York State. Mayor de Blasio has endorsed the decriminalization of marijuana and has already taken steps to prepare the City for this eventuality. In addition to changes in the City's marijuana enforcement policies that have been instituted by this Administration, Mayor de Blasio formed the Mayor's Task Force on Cannabis Legalization (Task Force) last summer, which has worked to develop goals, identify challenges and make recommendations to guide the City's preparation for legalization should a law change occur.

Along with other city agencies, ACS has been an active member of the Task Force, and in December 2018, the Task Force released a report with legislative, regulatory, and policy recommendations to help guide the State's discussion on marijuana legalization, and to identify the goals and challenges that should guide the City's preparations for potential legalization. One of these recommendations is directly related to ACS's work and clearly states that parental rights should not be impaired on the basis of cannabis use or cultivation unless it is endangering a child, a principle with which we concur and which is central to our current policies and practices.

ACS's Work to Promote Safety and Well-being in Cases with Substance Misuse Allegations

Let me briefly describe the reporting and investigation framework for our work. When a person suspects that a child is being abused or maltreated, they may make a report to the New York Statewide Central Register of Child Abuse and Maltreatment (SCR), which is administered by our state oversight agency, the Office of Children and Family Services (OCFS). If the State accepts the report, the report is sent to the county

(ACS for the 5 boroughs) to investigate. ACS has no discretion as to whether to conduct the investigation if the State accepts the report. ACS then has up to 60 days to conduct an investigation. Each year on average, ACS conducts about 60,000 investigations involving about 90,000 children. Approximately 20-25% of those investigations include allegations of substance misuse, usually together with other allegations.

ACS's goal during any child protective investigation is to assess child safety. All families and children are different, and our staff is charged with making highly individualized, nuanced assessments based on risks and strengths, and to then take appropriate actions to ensure child safety. By both state and local policy, neither a positive drug test of a parent nor a positive toxicology of a newborn baby, is in itself a basis for a determination that evidence of abuse or neglect exists. When investigating allegations of substance misuse, including misuse of marijuana, child protection staff must evaluate whether the parent's/caregiver's substance misuse has created a condition where the child's physical, mental, or emotional condition is negatively impacted or is in imminent danger of becoming negatively impacted, and must assess whether the parent's ability to care for and safeguard the child in the home is impacted by their substance misuse.

To assist child protective staff in cases involving substance use or misuse, ACS utilizes Credentialed Alcoholism and Substance Abuse Counselors (CASACs) as part of our Clinical Consultation Team. CASACs are certified substance misuse experts who are available to all CPS to provide support and technical assistance when child protective staff are assessing safety and risk in cases involving substance misuse allegations.

The child protection team works with the family to provide supports and respond to service needs that are identified as a result of the investigation. In the vast majority of cases in which ACS identifies an actual or potential risk to children, we work to keep

children at home with their parents or caretakers by engaging the family in prevention services. Where substance misuse is a safety concern, staff may make a referral for voluntary prevention services and/or treatment for substance misuse.

ACS's full continuum of prevention services is available to families where there is substance misuse impacting child safety. We work to best match a family's needs to the right type of service, which could be General Prevention services, Family Treatment and Rehabilitation services (FT/R), Special Medical services, or one of our Evidence-Based Models of prevention services.

Depending on the severity of the substance misuse concern and other service needs, the prevention services provider may work in partnership with a substance abuse treatment program to address the parent/caregiver's substance misuse and mitigate risk to the children in the home. In higher-risk cases where the primary safety concern is the parent or caregiver's substance misuse or mental health disorder, CPS may refer the family for FT/R. FT/R programs offer clinical diagnostic teams comprised of licensed therapists, CASACs, case planners, psychologist consultants, psychiatric consultants and other providers who work with families to develop treatment plans to address risk factors and bolster child safety.

More recently, we have begun to identify supports we can offer to families and communities independent of child welfare involvement, and with the goal of preventing such involvement altogether. Our Division of Child and Family Well-Being is developing a set of services, community-level interventions, and public education activities that can build on parents' strengths and protective capacities. Let me provide one relevant example. As you probably know, approximately 50 infants in New York City die every year because of unsafe sleep practices. Most often, that involves bed-sharing by parents and an infant,

and tragically, that often occurs when a parent is under the influence of alcohol or drugs. To help parents avoid this risk, just last month, we completed our citywide roll-out, in partnership with Health & Hospitals, to distribute our Safe Sleep Kit to maternity patients at the City's 11 H+H facilities. The Kits contain educational materials designed to be taken home by parents to share with family members and others who help take care of the new baby, and will reinforce the Safe Sleep information hospital staff are required by law to provide to maternity patients at the time of discharge. The Kits include a Safe Sleep Brochure, a Safe Sleep DVD, a wearable blanket (sleep sack), crib netting, an infant onesie, and a board book, "Sleep Baby Safe and Snug." This is an example of our focus on identifying services and supports that can assist parents in caring for their children and keeping them safe.

In summary, ACS's current policy requires our child protective staff to assess the impact a parent's substance misuse may be having on a child, regardless of whether the substance is alcohol, marijuana, prescribed drugs, or illicit opioids. Our goal, and our practice, is to intervene with drug treatment or prevention services to keep children safe at home whenever that is possible.

Mayor's Task Force on Cannabis Legalization Recommendations Directly Related to ACS and our Work with Families

While the legal context for marijuana may shift at the state level, ACS is committed to continuing our work with our sister city agencies to ensure that our policies and practices evolve congruently with any future changes in the law. As a member of the Task Force, ACS helped to develop and shape Section 2, Recommendation #14 of the December 2018 Report, which is that "Parental Rights Should Not be Impaired on the

Basis of Cannabis Use or Cultivation Unless Endangering the Child." ACS strongly endorses this recommendation, which includes the following components:

1. Child custody or visitation should not be denied on the basis of cannabis use or cultivation unless it places a child in danger: Our top priority for every family we encounter is the safety of the children, and this recommendation aligns with the agency's commitment to family preservation and child safety, and is also consistent with our current foster care policies.

2. No child should be the subject of a child neglect or abuse investigation or proceeding based solely on a parent's alleged use of cannabis: Anyone who suspects that a child is being abused or maltreated can call the State Central Register (SCR) to make a report. The State decides whether to accept the report. As I said earlier, if the State accepts the report of a New York City child, ACS has no discretion as to whether to investigate the report-- we are required by law to do so. The State should not accept and refer for investigation reports that do not contain allegations of risk to a child, such as reports based solely on a parent's alleged use of cannabis. We have been in conversations with the state Office of Children and Family Services (OCFS) and are verifying that the SCR does not accept substance use-related reports, nor refer cases to ACS to investigate, when there is no allegation of impact on child safety.

3) Cannabis use or cultivation should not generate a presumption of child neglect or endangerment: The focus of our investigations is on determining whether parents' actions have an impact on child safety or create a risk to children, and the use of cannabis in and of itself does not equate with risk of harm.

4) A positive cannabis test in and of itself should not equate automatically to a compelling measure of maltreatment in the context of child welfare: Our current policies and procedures require ACS to base safety and risk assessments on the *impact* substance misuse may have on child safety. A positive cannabis test in itself should never be considered maltreatment.

5) Cannabis should be defined as equivalent to a "drug" in the Family Court Act in order to remain within the ambit of substances that can lead to investigation or supervision of parents if a child is endangered by parental use, even if the cannabis use is not criminalized at the state level. In effect, cannabis use should be treated the same as alcohol use in the context of child custody: As previously stated, ACS' concern is not cannabis use itself, but the *impact* it could have on child safety, and that is the focus of our investigations. We will maintain that focus regardless of the criminality status of cannabis.

This Task Force Recommendation is consistent with ACS policy. In all areas of our work, we are constantly striving to ensure that our case practice is universally consistent with our policies. Similarly here, with regard to parents use or misuse of marijuana, we take active steps to ensure that our practice is aligned with all applicable policies. To do this, we use our robust quality assurance and oversight mechanisms to reinforce appropriate practice, including ChildStat, supervisory case reviews, Provider Agency Monitoring System case audits, and annual Collaborative Quality Improvement plans for our providers.

We recognize that the history of the criminal enforcement of marijuana laws has not fallen equally on all communities. The fact that marijuana is illegal – and that people of color and poor people have been disproportionately affected by enforcement – is a reality we cannot ignore. It is critical that we not allow bias or historical precedent to affect our decision-making, and we as an agency have committed to a number of steps to address and further equity across all of our work. This includes recently-launched, mandatory implicit bias training for all ACS staff, the creation of an Office of Equity Strategies, and a new equity assessment that will help us implement strategies that identify and forestall potential racial and other inequities in each of our program areas.

City Council Proposed Legislation

I will now turn to the bills under consideration by the City Council today. I believe we share the same goals and spirit as the Council in the areas embodied in the bills. As currently written, we have concerns about the bills' operational challenges, including the availability of some of the data that ACS would be required to report. As always, we are happy to work with the City Council to address these concerns.

Intro 1161

ACS appreciates the City Council's interest in better understanding the allegations ACS investigates. ACS currently provides quarterly child welfare reports to the City Council pursuant to Local Law 20 of 2006. This bill would amend this law to require ACS to disaggregate our current child welfare quarterly report by the numerous, specific allegation types listed in the bill.

ACS is required to use the state system of record, Connections, to track child welfare cases. Due to limitations of the Connections system, we do not currently have the technical capacity to aggregate allegation data regarding use of marijuana (or any specific drug). The State launched new upgrades to Connections in mid-January 2019, which will eventually allow us to develop some new reporting functionality. While there has not yet been training on the new fields, the State released some preliminary guidance at the end of March regarding the use of the new fields, which include dropdowns for child protective staff to select specific substances parents or caretakers are found to be using or misusing. According to the guidance, however, the state does not intend the new functionality to track the specific drug(s) in child welfare allegations, which is what the City Council legislation is seeking ACS to report on.

We are currently having additional conversations with the State to see if the system can provide greater specificity with regard to maltreatment allegations, and whether it could provide the capacity in the future to capture specific drugs in those allegations. Lastly, we are also still clarifying with the State how the new data will be accessible for data reporting by ACS. We look forward to discussing this further with the Council as soon as we have more clarity.

The current quarterly child welfare report also includes a number of child welfare related statistics, some elements of which are now outdated, including items related to caseload and workload. As you know, Local Law 18 of 2018 requires ACS to conduct a workload study pertaining to our CPS staff, which is currently underway. ACS is due to issue a report on the findings of the study to the Council in September of this year, and we anticipate the information in that report will be useful in informing amendments to Local Law 20.

ACS is committed to transparent information-sharing with the Council, and we are happy to engage in further discussion about how best to update Local Law 20 to be useful and informative to the Council and other stakeholders. ACS looks forward to working with the City Council on options that could be available given ACS's data limitations related to the statewide system of record. We respectfully urge the Council to hold Intro 1161 pending further conversation with ACS and submission of the agency's workload study report in September.

Intro 1426

Intro 1426 would require ACS to report annually on the number, type and outcomes of investigations initiated by ACS as a result of positive drug screens from drug tests performed at facilities managed by NYC Health + Hospitals (H+H). The proposed bill would also require us to disaggregate this information by H+H facility and a number of other factors such as age, income, gender, ethnicity, date of drug test, different types of drugs, the number of investigations initiated by ACS, and the outcomes of those investigations.

We appreciate the Council's intent to better understand systems and processes that affect the everyday lives of New Yorkers. A core part of our agency's vision is to identify and confront the disproportionate impact the child welfare system has had on historically marginalized groups. ACS is taking important steps to address these issues through primary prevention services and equity-focused initiatives. However, this bill presents a number of operational concerns and other challenges that we look forward to discussing further with the Council.

As written, the bill does not accurately capture the process of how a family might come to the attention of ACS, which creates fundamental operational challenges in

producing such a report. The draft bill presumes H+H would be referring cases to ACS directly and ACS would determine when to do an investigation. This does not happen. Whenever a report of suspected abuse or maltreatment is made, the report goes to New York State, the State determines whether to accept the report, and then sends it to the appropriate county to investigate. By law, ACS is required to investigate any report we receive from the State—we have no discretion with regard to determining whether to conduct an investigation.

In addition, the bill would require ACS to disaggregate the data in ways that we are not technologically able to do and, in some instances, may not have the requested information at all. Additionally, we are concerned about the unintended consequences that may arise from legislation requiring the collection of personal information and public reporting of data. This reporting requirement may create a chilling effect on reporters' willingness to call the SCR, even when there is a serious child safety risk, and may also dissuade people from seeking medical attention to avoid having their personal information shared with government entities for the purpose of collecting data for a public report. Finally, we are concerned that the level of specificity in the aggregation required by the proposed bill could unintentionally impact a parent's confidentiality.

Closing

Thank you for the opportunity to discuss how the legalization of marijuana would impact child welfare. To reiterate and quote from the recommendation from the Mayor's Task Force: "Cannabis use should not generate a presumption of child neglect or endangerment. Nor should a positive test in and of itself equate automatically to a compelling measure of maltreatment in the context of child welfare." Our case specific

determinations now and in the future must focus on the safety of children and the support of families.

We also thank you for the opportunity to discuss the City Council's proposed legislation. We appreciate the Council's leadership and focus on these important topics and look forward to working with you to refine the bills so they can best serve the interests of New York City children and families, and the dedicated workforce who serve them. We are happy to take any questions.

Testimony of Shakira Kennedy

NYS Assembly Hearing on Allowing Use of Marijuana
March 4, 2019

Thank you to the New York City Council for the opportunity to be here. My name is Shakira Kennedy and I am extremely honored to be here and be heard. I am here to stand up for all the parents who cannot – the downtrodden parents who try to live their lives as best they can, but are continuously beaten down by a system of oppression. I am talking about marijuana prohibition and the abuse Black and Latinx parents face from children's services – and what needs to change.

I am 28 years old, a loving mother, a parent advocate, and a taxpaying New Yorker. I have a beautiful 7 year-old daughter who goes to one of the top schools in Brooklyn in the Gifted & Talented program. She's also a girl scout.

I recently gave birth to two beautiful twin boys. Unfortunately, I suffered from extreme and prolonged morning sickness during my pregnancy and could not keep food or water down. I sought the best medical care and my doctors told me I needed to gain wait for the health of the fetuses. But all of the medicine they gave me didn't work. Nothing did, until I tried cannabis. Making sure to tell my doctor everything, I disclosed that I used cannabis and it helped me eat normally.

That is when I became a victim of my circumstances. When my twins were born, the hospital drug tested me without telling me. They found marijuana in my system, but not in my children. Still, the hospital called ACS.

I made clear to ACS that I had to use marijuana under these unique circumstances but that I would not continue to use it and asked to schedule a drug test to prove that it would no longer be in my system, but they made me go to court. Then, instead of ongoing drug testing as I requested, I was required to go to an outpatient rehab program three days a week. Again, I do not use drugs or have any addiction, but right out of the hospital I had to attend this program when I should have been healing and bonding with my babies. I had to go to this treatment program for the first three months of my babies' lives – and to bring them because ACS didn't offer me childcare. I was taking a spot in a treatment program that could have gone to somebody who actually needed it.

I had complete strangers from Children's Services coming into my home and telling me what to do as a parent and threatening to remove my children.

I don't even trust giving a credit card at a restaurant, because I worry about ID theft, but I have to give out my children's social security card, birth certificates and doctors' records to this stranger and they could use it for any reason. I have no privacy while ACS is in my children's life. The level of harassment I have received from them is completely unprofessional and overpowering. As a parent, I felt like I was in jail, even though there were no handcuffs on my hands. ACS is like a Correction Officer. They are not trained to solve people's problems.

Before ACS got involved, me and the father of all three of my children were doing well and planning to get married but ACS scared him away, accusing him of "witnessing me smoke marijuana," and now he is out of contact. He was my support and they ruined that.

I have proven my love and dedication as a parent through my daughter. I always seen the star in her – and done everything for her. I'm a success story. I live for my children.

In the program, I saw that almost everyone was there for marijuana. I do not believe this medicinal plant should be treated as other man-made drugs. It has been proven to help people with mental and physical problems across the globe. Why is it still looked at as a negative drug? Why? Racism and classism. It is the only way to keep the jails packed and to keep the poor poor. You have to go to these mandatory services, and you can lose your job. Programs try to work around your schedule but they can only go so far.

I support full legalization because our crime rates will decrease and there will be less blood in the streets. Drugs will be more safely regulated. Legalization would build up and economically empower the community and reduce wasteful police enforcement. Unless the parent is using marijuana recklessly, this should not be a consideration in family court.

But I see it very clearly: They put the men in jail and sic ACS on the women. Something has to change. This is not right. We need to end marijuana prohibition, repair the harm of the drug war, and reinvest the profits in our communities – MTA funding, drug treatment for people who *actually* need it, and more – and we need to do it now.

I support the Marijuana Regulation and Taxation Act for many reasons, but one is that it should end the kind of abuse I have faced from ACS. And as the state negotiates marijuana legalization this year, they must not forget about parents like me. One day you or someone you love may be harmed and victimized the same way I am. Do not take a step forward and leave us behind. We all deserve justice.

Thank you.

We are the Drug Policy Alliance.

To: New York City Council Committee on General Welfare
New York City Council Committee on Hospitals

Date: April 4th, 2018

Re: "The Impact of Marijuana Policies on Child Welfare."

The Drug Policy Alliance appreciates the opportunity to submit testimony to the New York City Council's Committee on General Welfare and Hospitals on the Impact of Marijuana Policies on Child Welfare. The Drug Policy Alliance is the nation's leading organization working to advance policies and attitudes to best reduce the harms of both drug use and drug prohibition and to promote the sovereignty of individuals over their minds and bodies.

The Drug Policy Alliance has led campaigns to end the prohibition and criminalization of marijuana use, sales, and possession. The campaigns organized in New York and throughout the country are based on our fundamental belief that ending marijuana prohibitions is a civil rights issues, as laws criminalizing marijuana use predominantly impact Black and Latinx people.

In legal states, marijuana arrests are continuing to plummet and a range of positive externalities have been observed, including reductions in opioid overdose deaths, decreases in DUI arrest and increases in tax revenue.[1] DPA has learned valuable lessons from every campaign and every state that now has a legal marijuana market, we want to ensure that there is relief for those harmed by criminalization and that every agency working to stigmatize and punish people who use drugs moves towards truly embracing harm reduction.

Our commitment to ending the war on drugs extends beyond criminal justice reform, we want to call upon every system to account for their participation in the racist, criminalization of the people who use drugs – this include the Administration for Children Services.

After Colorado established a recreational marijuana market, the state experienced an increase in abuse and neglect investigations and the Department of Human Services could not provide a detailed account as to what drove the increase in investigations, and if it's directly related to marijuana. Like New York, Colorado's child welfare department's computer system did not track drug-specific information.[2] The Colorado experience made us aware of the consequences of not creating comprehensive legalization recreational marijuana policy and the administrative work that must occur to maintain accountability and transparency. The slate of legislation introduced by the council is a step towards pushing ACS away from harmful interventions that contribute to family separation.

INT 142-2019: Reporting on investigations initiated by the Administration for Children's Services resulting from drug screenings performed at facilities managed by the New York City health and hospitals corporation.

New York's Health and Hospital corporations' policy and procedure regarding screening a pregnant person for alcohol use and exposure to other drugs requires the medical provider to obtain verbal consent prior to delivering a drug test. The pregnant person also must be informed of how the results will be used for her medical care and the care of the unborn or newborn child. It is unclear as to how this policy is implemented as there is no data on the breadth of drug testing and the number of pregnant people reported to the SCR as a result of positive toxicology. While the proposed policy does address the lack of transparency in ACS, it doesn't address the problem of drug testing mothers without informed consent and the drug testing of newborns without any consent from the parents.

DPA asks that the Council not only support reporting legislation but also challenge the use of drug testing on pregnant people prior to delivery or the testing of newborns postpartum. The resolution introduced by Councilmember Rivera asking the State Department of Health to create clear regulation is significant, but the Council can and should use its oversight power to take action to address New York City hospitals.

In New York, Black pregnant people and newborns are more likely to be screened for prenatal drug exposure than white pregnant people.[3] While the screening of black pregnant people and babies occurs at higher rates, white pregnant people and children screened for drug exposure are more likely to test positive for drug exposure.[4] This is not an invitation for HHC to test more pregnant people, but rather for HHC to assess the criterion for testing so that screening decisions support the long term health and wellness of the parent and child.

DPA makes the following recommendations to improve both reproductive health care and data transparency:

- Pregnant people consenting to drug testing must be fully cognizant and medically able to make informed decisions. This means that pregnant people who are in the early stages of delivery should not be asked to consent to a drug test as they are likely unable to give informed consent in a state of medical duress.
- Medical providers should receive written consent to perform a drug screen after providing a detailed explanation of the medical utility of the test and the potential for the results to be shared with ACS.
- If the newborn is tested for drug exposure, parent(s) should be informed of the results and any subsequent reports made to the SCR.
- A positive toxicology report should not contribute to the parent(s) separation from the newborn absent any substantial evidence of abuse or neglect unrelated to substance use.
- HHC should receive regular training on the nuances of CAPTA legislation and their responsibilities as mandated reporters. Too often, physicians report any and all substance use to ACS but that is not always required of them.

The legislation proposed by Councilmember Reynoso will be a benefit for advocates who have little data to support their claims that ACS initiates or prolongs supervision of a parent/caregiver in response to substance use allegations in which the primary substance is marijuana.

The legislation introduced by Councilmember Reynoso can be strengthened and we recommend the following considerations to improve data collection.

- ACS should report as to whether or the drug test was administered to the newborn or the parent.
- ACS should report on the race of each patient, as race and ethnicity are different categories.
- ACS should report the number of reports made from HHC that were substantiated or unsubstantiated.

The Council should also consider amending the legislation to reflect our desire for data transparency, as the legislation is currently written the data will only be accessible to the Mayor and members of the City Council. This lack of transparency will stymie administrative accountability and the development of community-oriented solutions to transform the child welfare system.

Int. No. 1161: A local law to amend the administrative code of the city of New York, in relation to enhanced reporting on the child welfare system

In 2018, the Council held a hearing on parent separation. When questioned about the influence of marijuana use on family reunification decisions and neglect allegations, the ACS representative stated that marijuana use alone does not lead to ACS investigations or the placement of children in out of home care. [5]This admission is contradictory to the experiences relayed to us by parents, family defense attorneys, and other advocates. Unfortunately, there is little data to counter the prevailing narrative as the current data on neglect and abuse allegation reported by ACS does not provide details as to the nature of the allegation. Without this data, we are unable to discern whether or not ACS is maintaining fidelity to the legal definition of parental neglect, which requires evidence to indicate that a parent's substance use is a contributing factor leading to emotional, physical or mental abuse of the child.[6]

For these reasons, DPA supports legislation requiring the Administration for Children's Services to report the main allegations that contributed to a statewide central registry report, or resulted in the opening of a case for investigation of child abuse or neglect.

We recommend the following additions to the legislation:

While it is important to protect parents who chose to use marijuana recreationally and responsibly, we must not inadvertently deepen the stigma already experienced by parents who use drugs beyond marijuana. We ask that bill be amended to include the following:

- Outcomes of cases wherein the allegations include substance use, marijuana or otherwise
- Causal factors contributing to TPR and if the primary justification for termination of parental rights is continued substance use.

Res 0740 - Resolution calling upon the New York City Administration for Children's Services to implement a policy finding that a person's mere possession or use of marijuana does not by itself create an imminent risk of harm to a child, warranting the child's removal

The resolution introduced by Councilmember Lander speaks to the crux of our problem with ACS. While marijuana use alone does not regularly trigger neglect investigation, marijuana or a drug use prolongs

investigations as ACS requires complete abstinence regardless of whether or not the caregiver(s)' substance use has an impact on the rearing or the child. Increasingly, largely white, wealthy and otherwise privileged parents are openly expressing the benefits of consuming marijuana while parenting without drawing the scrutiny of child welfare agencies. This indicates that the issue isn't the substance, it's the people or communities associated with its use. Once marijuana becomes legal in New York, everyone must feel free to use the substance without fear of punishment or stigma.

This resolution supports this cause, but it is also imperative that ACS shift its organizational priorities to become an agency of support and harm reduction, instead of punishment and enforcement

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[1] *From Prohibition to Progress: A Status Report on Marijuana Legalization What We Know About Marijuana Legalization in Eight States*. www.drugpolicy.org/sites/default/files/dpa_marijuana_legalization_report_feb14_2018_0.pdf. Accessed 25 Feb. 2019.

[2] Brown, Jennifer. "Drug-Related Child Welfare Cases Have Increased in Colorado, but Connection to Legalized Marijuana Is Unclear." The Denver Post, The Denver Post, 24 Dec. 2016, www.denverpost.com/2016/12/23/drug-child-welfare-cases-colorado-have-increased-in-colorado-but-connection-to-legalized-marijuana-is-unclear/.

[3] Norton, Amy. "Black Babies More Often Screened for Drug Exposure." *U.S.*, Reuters, 18 May 2010 www.reuters.com/article/us-drug-exposure-idUSTRE64H4LF20100518.

[4] Ibid.

[5] New York City Council Hearing. Oversight – Parent Child Separation in Family Court. Comments from Deputy Commissioner Sputz (November 2017)

[6] "New York Consolidated Laws, Family Court Act - FCT § 1012 | FindLaw." *Findlaw*, 1 Jan. 2019, codes.findlaw.com/ny/family-court-act/fct-sect-1012.html.

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Planned Parenthood of New York City

Testimony of Planned Parenthood of New York City
Before The New York City Council
Committee on General Welfare and Committee on Hospitals
Regarding the Impact of Marijuana Policies on Child Welfare

April 10, 2019

Good Morning. My name is Clarke Wheeler and I am a Government Relations Associate at Planned Parenthood of New York City. I am pleased to submit testimony for today's public hearing on the impact of marijuana policies on child welfare. Thank you to Committee Chairs Levin and Rivera, as well as the Committees on General Welfare and Hospitals, for convening this hearing, and to the Speaker and Council Members Richards, Reynoso, Lander, and Rivera for introducing this important legislation. Planned Parenthood of New York City supports Introductions 1161-2018 and 1426-2019, as well as Resolutions 0740-2019 and 0746-2019.

Planned Parenthood of New York City (PPNYC) has been a leading provider of reproductive and sexual health services in New York City for over 100 years, seeing over 91,000 visits to our health centers and reaching an additional 25,000 New Yorkers annually through our education programs. As a healthcare provider, we recognize the vital importance of building trusting relationships between our patients and providers. Our patients often come from communities that have historically experienced medical violence and may continue to lack trust in the healthcare system. One of the persistent forms of medical violence in our healthcare system is the practice of punishing and separating families based on a parent's substance use. In New York City, this is a crisis impacting communities who also routinely experience sexual and reproductive oppression, including women of color, immigrants, and low-income New Yorkers.

Across the country and here in New York, we are witnessing a push to legalize marijuana as a way to begin to address the massive inequities and violences perpetuated by the so-called "war on drugs." Legalization of marijuana is an important first step, but we know that it is insufficient in addressing the needs of communities of color who have been targeted by punitive drug policies for decades. In the child welfare system, parental marijuana use is frequently seen as an indicator of child abuse and neglect, and ultimately as the basis for family separation.[1] The idea that newborns and children should be separated from their parents because of marijuana use is

[1] Gwynne, Kristen. "How Marijuana Legalization Leaves Mothers and Pregnant Women Behind." Rewire News. May 12, 2014.
https://rewire.news/article/2014/05/12/marijuana-legalization-leaves-mothers-pregnant-women-behind

rooted in racist, classist, and misogynistic ideologies that specifically target women of color and low-income parents and communities. Across the nation, black children face double the likelihood of entering foster care as white children.[2]

A number of commonly held misconceptions about substance use contribute to the demonization and criminalization of mothers and parents who use marijuana. However, a 2016 study found that marijuana use during pregnancy is not an independent risk factor for adverse neonatal outcomes after adjusting for confounding factors.[3] Studies also show a double standard when it comes to marijuana use and parenting. In fact, Black Americans use drugs at approximately the same rates as white Americans, but are ten times more likely to go to prison for drug offenses.[4] In one study, black women who tested positive for illegal substances were 10 times more likely to be reported to child protective services.[5]

Punishing mothers for using marijuana does not improve the health and wellness of parents and families. Studies show that these punitive measures often deter mothers and parents from maintaining honest and open relationships with their health providers and prevent them from seeking the healthcare they need.[6] The legislation being discussed today creates an opportunity for the city to begin to address the impact of marijuana policies on our child welfare system, and its particular harm on communities of color.

PPNYC supports the passage of Introduction 1161, which requires the Administration for Children's Services (ACS) to report the main allegations that led to its receipt of a report or the opening of a case for investigation of child abuse or neglect. We also support Introduction 1426,

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[2] Saberi, Roxana and Lisa Semel. "In NY, black families more likely to be split by foster care system." Al Jazeera America News. June 24, 2015. https://www.google.com/url?q=http://america.aljazeera.com/articles/2015/6/25/new-york-foster-care-system-racial-disparity.html&sa=D&ust=1554496508058000&usg=AFQjCNERPUs7AtFixXp8zmC9b8iVVGfKrg

[3] Conner, SN et al. "Maternal Marijuana Use and Adverse Neonatal Outcomes: A Systematic Review and Meta-analysis." Obstet Gynecol. 2016 Oct;128(4):713-23. https://www.ncbi.nlm.nih.gov/pubmed/27607879

[4] Fellner, Jamie. "Decades of Disparity: Drug Arrests and Race in the United States." Human Rights Watch. March 2009. https://www.hrw.org/sites/default/files/reports/us0309web_1.pdf

[5] "Criminalizing Pregnancy: Policing Pregnant Women who Use Drugs in the USA." Amnesty International. 2017. https://www.amnesty.org/download/Documents/AMR5162032017ENGLISH.pdf

[6] "Substance abuse reporting and pregnancy: the role of the obstetrician–gynecologist." Committee Opinion No. 473. American College of Obstetricians and Gynecologists. Obstet Gynecol 2011;117:200–1. https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Substance-Abuse-Reporting-and-Pregnancy-The-Role-of-the-Obstetrician-Gynecologist?IsMobileSet=false

which requires reporting on investigations initiated by ACS resulting from drug screenings performed at facilities managed by NYC Health + Hospitals (H+H). We urge the Council to pass these pieces of legislation, which will clarify how child abuse and neglect cases are opened and how drug screenings ultimately lead to ACS investigations.

PPNYC also supports Resolution 740, which calls upon ACS to implement a policy finding that a person's mere possession or use of marijuana does not by itself create an imminent risk of harm to a child, warranting the child's removal. This Resolution would counteract popular misconceptions about parents who use marijuana and ideally decrease the likelihood that families will interact with the child welfare system. Finally, PPNYC supports Introduction 746, which requires the New York State Department of Health to create clear and fair regulations for hospitals on drug testing those who are pregnant or giving birth, including informing patients of their rights before any discussion of drug use or drug testing. It is critical that we empower patients with their rights in hospitals and other healthcare settings, in an attempt to address historic and ongoing human rights violations against communities who face barriers to care.

In the face of attacks from a federal administration that is intent on separating families, New York City must be a leader in keeping families together and upholding reproductive justice in our child welfare systems. PPNYC urges the Council to pass this critical legislation and looks forward to continued partnership with the City as we work to improve the lives of all children and families.

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Since 1916, Planned Parenthood of New York City (PPNYC) has been an advocate for and provider of sexual and reproductive health services and education for New Yorkers. Through a threefold mission of clinical services, education, and advocacy, PPNYC is bringing better health and more fulfilling lives to each new generation of New Yorkers. As a voice for sexual and reproductive health equity, PPNYC supports legislation and policies to ensure that all New Yorkers—and, in fact, people around the world—will have access to the full range of sexual reproductive health care services and information.

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Hearing on the Impact of Marijuana Policies on Child Welfare Before the Committees on Hospitals and General Welfare

Testimony of Nahal Zamani, Advocacy Program Manager,
Center for Constitutional Rights

April 10, 2019

I. INTRODUCTION

We would like to thank the Committees on Hospitals and on General Welfare of the New York City Council for holding this critical hearing today. The Center for Constitutional Rights works with communities under threat to fight for justice and liberation through strategic litigation, advocacy and communications.[1]

In our testimony today, we focus on the practice of disproportionate drug testing of Black women in New York City hospitals, the exposure to potentially devastating collateral consequences for them and their families, including the potential for family separation. We applaud efforts by the City Council to would increase public reporting on the prevalence of this practice and for two resolutions which urge policy and legislative changes which would end the harmful impact of this practice.

[1] Since 1966, we have taken on oppressive systems of power, including structural racism, gender oppression, economic inequity, and governmental overreach. Learn more at https://ccrjustice.org.

As the two Committees are well aware, the practice of exposing mothers and their newborn infants for testing for drug use in New York City hospitals targets Black mothers. Investigations for marijuana use alone can then compel unnecessarily interventions.

Several actors play a key role in this phenomenon. Health workers and hospital staff engage in racially biased testing for illicit drug use, and their actions lead to involvement of the Statewide Central Register of Child Abuse and Maltreatment (SCR) and the New York City Administration for Children's Services (ACS) and related interventions.[2] This multi-layered practice evokes discrimination, stigmatization, and failing government interventions divorced from the realities of science and harm reduction.

Today, our testimony highlights the discriminatory targeting of drug testing for new mothers and their newborns; the impacts of ACS investigations and potential removals on the basis of mere marijuana usage among mothers; the need for a harm reduction approach in the health care setting which reduces and ultimately ends stigma; and the disconnect between this practice and the national conversation to legalize marijuana.

II. Racial Impacts and Disparities: From Pregnancy to the Postpartum Setting

The role of the government, and its agencies – at all levels – impacts peoples' lives in profound ways. Government practices and interventions must be grounded in the empowerment of people to live a life with dignity and freedom from harm. In the instances where government policies are outright harmful and / or enforced in a discriminatory manner, they must be ended immediately. The intersection of government actions on Black women's lives is profound during pregnancies and in the postpartum setting.

Despite the comparable use of marijuana in general among Blacks and Whites, racial disparities are profound in the healthcare settings. Black women are already more likely to be tested for drug use during their pregnancies,[3] and they face severe racial disparities in the postpartum setting, further compounding exposure to "adverse consequences from intervention by legal or social service agencies."[4] The combined impact of health workers and child protective service

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[2] As the Daily News reports, this phenomenon has been documented in the public hospital setting (of which the City Council exercises oversight), but also occurs in private hospitals which service populations on uninsured patients or those who are on Medicaid. Yaniv, Oren, *WEED OUT: More than a dozen city maternity wards regularly test new moms for marijuana and other drugs*, New York Daily News, December 29, 2012, available: https://www.nydailynews.com/new-york/weed-dozen-city-maternity-wards-regularly-test-new-mothers-marijuana-drugs-article-1.1227292 (hereinafter "NY Daily News: Weed Out").

[3] Neuspiel DR. Racism and perinatal addiction. Ethnicity and Disease. 1996; at 47–55, available https://www.ncbi.nlm.nih.gov/pubmed/8882835; Kunins, Hillary Veda., et al., The Effect of Race on Provider Decisions to Test for Illicit Drug Use in the Peripartum Setting, J Womens Health (Larchmt). April 24, 2010, available: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2859171/ (hereinafter "The Effect of Race on Provider Decisions to Test for Illicit Drug Use").

[4] The Effect of Race on Provider Decisions to Test for Illicit Drug Use at 6.

agencies' interventions, at its worst, can lead to findings of child neglect, loss of parental rights and threats of or instances of family separation.

While this is surely a national phenomenon, New York should be innovative in reducing stigma and addressing racial disparities in the healthcare setting. We can take necessary steps to expose racial disparities and closing the gaps which allow for these unnecessary interventions. The bill package promoted by the City Council represents a crucial first step.

III. CURRENT CHILD WELFARE INTERVENTIONS ARE OUT OF STEP WITH HARM REDUCTION APPROACH AND MARIJUANA LEGALIZATION EFFORTS

As the City Council and the media have discussed at length,[5] pursuing child neglect cases merely on the basis of marijuana usage by parents reflected a misguided government intervention. It is both divorced from the discussion to legalize marijuana as well as the growing precedent to embrace harm reduction in health care settings.

The State of New York is on the cusp of legalizing marijuana. And yet, ACS plays a critical role in contributing to the criminalization of mothers who are perceived to have engaged in marijuana use. Investigations which lead to the removals of children based solely on positive toxicology at birth of marijuana are clearly harmful and unnecessary. As advocates and experts have testified today, these policies are out of step with recent efforts to reduce the stigma of drug use and with the growing understanding about the less detrimental effects of such use on fetuses during pregnancy.

In recent years, there have been great strides towards the integration of a harm reduction approach in the health setting. As such, doctors and health workers can best guarantee the wellbeing of their patients during their pregnancies and deliveries by maintaining open

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[5] New York City Council Committee on Hospitals, jointly with Committee on General Welfare, Hearing T2019-3915, Oversight - Impact of Marijuana Policies on Child Welfare, April 10, 2019, Hearing and related legislative package (including Intro 1161-2018 [A Local Law to amend the administrative code of the city of New York, in relation to enhanced reporting on the child welfare system], Intro 1426-2019 [A Local Law to amend the administrative code of the city of New York, in relation to reporting on investigations initiated by the administration for children's services resulting from drug screenings performed at facilities managed by the New York city health and hospitals corporation], Resolution 740-2019 [Resolution calling upon the New York City Administration for Children's Services to implement a policy finding that a person's mere possession or use of marijuana does not by itself create an imminent risk of harm to a child, warranting the child's removal] and Resolution 746-2019 [Resolution calling on the New York State Legislature to pass, and the Governor to sign, legislation requiring the New York State Department of Health to create clear and fair regulations for hospitals on drug testing those who are pregnant or giving birth, including informing patients of their rights before any discussion of drug use or drug testing]), available: https://legistar.council.nyc.gov/MeetingDetail.aspx?ID=684838&GUID=8588C279-C87B-4CF6-BF63-03F964CD1787&Options=info&Search=; NY Daily News: NY Daily News: Weed Out; Secret, Mosi, *No Cause for Marijuana Case, but Enough for Child Neglect*, August 17, 2011, available: https://www.nytimes.com/2011/08/18/nyregion/parents-minor-marijuana-arrests-lead-to-child-neglect-cases.html; Lawson, Kimberly, *Black Mothers Share the Devastating Impact of Racism in Maternal Health Care*, VICE, available: https://broadly.vice.com/en_us/article/43bp43/black-maternal-health-care-racism-stories.

communication about the circumstances that shape their patients' lives. Committing to harm reduction and to the reduction of stigma means identifying and ending health interventions which promulgate racial disparities and negative health outcomes.

This draconian approach of conflating child welfare with marijuana usage is the opposite of the harm reduction approach – it is actually *harmful*. Accordingly, Resolution 746 recognizes the need for the sharing of one's medical history with their health care provider without fear of the opening of a child welfare case. The resolution also questions the utility of inclusion of a positive drug test into the legal definition of neglect.

We also must reduce harm and stigma in health services. There are clear disparities in practices at hospitals around who is subjected to drug testing , the obtaining of patient consent, the adequate informing of patients of potential impacts of such testing, as well as policies around newborn testing in cases of parent refusal. These disparities, along with their ramifications for parents, should be addressed. Taken together, these disparities compound health and social outcomes for communities of color.[6] Wherever possible, as Resolution 746 implies, best practices in health settings which center the wellbeing of parents and their families and which reduce stigma and harm must prevail.

While our colleagues have highlighted the necessity not to further stigmatize parents who use drugs beyond marijuana, we do uplift however, the uniqueness of marijuana use and impacts stemming from positive toxicology tests from its usage for new parents. Accordingly there is growing acknowledgement of a less harmful impact from marijuana use on fetal health.[7] Despite this, ACS's policies, and the actions of health workers and providers who decide to test for drug use, ultimately equate marijuana use alone with neglect and abuse. Therefore, as the City Council rightfully recognizes in their bills, while there has been greater public acceptance of the marijuana use, the prevailing mechanisms around child welfare are greatly falling behind.

Moreover, as my fellow advocates have testified regarding their clients who have had loved ones removed from a simple positive drug test for marijuana usage -- is this really the most effective and sound intervention that health workers, ACS and New York City can make? Are these the most crucial examples of neglect and child welfare which ACS should focus on? And do these practices simply promulgate stigma and spread harm? These questions underline the need for stronger protections, better laws, and guided policies which reduce harm and are in line with our national conversations.

[6] NY Daily News: Weed Out.
[7] NY Daily News: Weed Out.

IV. Discussion of Bill Package

To be sure, the practice of testing new mothers for drug use is common across the country, as is the disproportionate impact and consequences on black women.[8] However, if NYC wants to truly be a progressive, national leader for policy setting, we can and must do better.

Anecdotal evidence confirms the discriminatory impact here in New York, and we need more public reporting to shed a light on this practice.[9] To that aim, Intro 1426 (which increases public reporting on ACS investigations resulting from positive drug tests at New York City Health and Hospitals Corporation [HHC] facilities) will help ensure reporting on ACS' initiating or prolonging of child welfare investigations and such investigations' intersection with the use of marijuana. With regards to this bill, it is crucial to compel reporting on race, a greater understanding the implications of unsubstantiated findings, the circumstances under which parents may remain on the SCR lists, and the ramifications on their lives for such inclusion.

Intro 1161 (which promotes enhanced reporting on allegations which lead to opening of cases of child abuse or neglect in the child welfare system) is equally important. The bill should also consider the outcomes of cases wherein the allegations include substance use, marijuana or otherwise; the factors contributing to the termination of parental rights; and whether the primary justification for such termination is continued substance use.
We support Resolution 740 (calling on ACS to implement a policy finding that a person's mere possession or use of marijuana does not by itself create an imminent risk of harm to a child, warranting the child's removal), and call on ACS to reconsider its policies which conflate drug use in and of itself as a factor of neglect, to come into line with applicable state laws and to embrace instead interventions that support harm reduction and family preservation.

Last, with regards to Resolution 746, we commend the bill sponsors for urging the state legislature and the governor to take concrete steps towards streamlining hospital procedures including addressing disparities in testing and basis for testing throughout hospitals; determining why and how hospitals communicate with SCR, and ensuring such communications are grounded in law and harm reduction approaches; ensuring that consent is always obtained and that patients are informed of potential outcomes when giving such consent; and to enshrining and mandating best practices.

V. Family Preservation: The Need for Uninterrupted Bonding and Attachment as a Crucial Element of the Postpartum and Perinatal Setting

We draw the City Council's attention to key issues in the postpartum or perinatal setting. The prevailing literature indicates that bonding, particularly in this period is essential for a multitude

[8] The Effect of Race at 6.
[9] NY Daily News: Weed Out.

of reasons for the wellbeing of mother and child. Any potential interruptions for bonding, including the threat of or an actual interruption or separation, has incredible ramifications.

Childbirth and the immediate period thereafter is an incredible and complicated experience. We should question the utility of adding a layer of the threat of or an actual interruption in the bonding period with a newborn. For example, a crucial element of bonding at this stage is the establishment of breastfeeding. One of the best known health outcomes for infants is their access to and ability to breastfeed. For mothers who chose to breastfeed, the ability to establish adequate milk supply in the first few days after birth is crucial and dependent on a range of factors, including unfettered access to their newborns.

Removals – whether they last three days or several weeks – has serious ramifications for bonding, the ability to establish breastfeeding, and the wellbeing of infants. The threat of and actual separations can greatly damage such bonding. We should ensure all families have access to the best health outcomes possible at this crucial time.

VI. CONCLUSION

In light of the incredible strides to embrace harm reduction, to legalize marijuana, and to reduce stigma, New York can improve families' lives. We urge the City Council to consider taking the crucial steps we have underlined in our testimony. We thank you for hearing our testimony today.

BROOKLYN DEFENDER SERVICES

TESTIMONY OF:

Nila Natarajan – Supervising Attorney, Family Defense Practice
BROOKLYN DEFENDER SERVICES

Presented before

The New York City Council Committee on General Welfare and Committee on Hospitals

Joint Oversight Hearing on the Impact of Marijuana Policies on Child Welfare

And

Intro 1161-2018, Intro 1426-2019, Res. 0740-2019, Res. 7426-2019.

April 10, 2019

My name is Nila Natarajan and I am a Supervising Attorney in the Family Defense Practice at Brooklyn Defender Services (BDS). BDS provides multi-disciplinary and client-centered criminal, family, and immigration defense, as well as civil legal services, social work support and advocacy in approximately 30,000 cases in Brooklyn every year. This has included thousands of people arrested for marijuana possession or sale, and people fighting deportation, eviction, or a loss of custody or parental rights due to marijuana-related allegations or convictions. We are grateful to the New York City Council for holding this hearing and taking an in-depth look at how the child welfare system treats marijuana use in New York City – including its deep-seated and stark racial inequities. We strongly support the two bills and two resolutions proposed by the City Council and appreciate this opportunity to comment on them.

BACKGROUND

BDS is the primary provider of legal representation to parents in child welfare cases in Brooklyn Family Court, one of the busiest family courts in the country. New York State law does not allow marijuana use to be the sole basis for removing a child from a parent; making a finding of neglect against a parent; or denying that parent visitation with their child. Yet my colleagues and

I witness these and other extreme and prolonged consequences of parental marijuana use in family court every day – even when there is no evidence that a parent uses marijuana in the presence of their children or that the children are in any way harmed by the parent's use.

Just last week, in a case we picked up on the first day the neglect petition was filed, ACS requested that, as a condition of allowing our client's child to remain with her, she submit to a Credentialed Alcoholism and Substance Abuse Counselor (CASAC) evaluation and *ongoing* random drug screens. The petition filed against our client essentially only made allegations of homelessness. When questioned about the basis for the request for the evaluation and drug screening, ACS stated that our client admitted to using marijuana prior to becoming pregnant, seven months earlier. Although ACS had *not* raised marijuana use as a basis for neglect, ACS still threatened the removal of our client's child if she refused to submit to random drug screens and asked the court to hold a hearing on that matter if she did not submit.

Given the widespread use of marijuana by people across race and income levels, it is not surprising that many low-income parents use marijuana to relieve stress, manage pain or nausea, or enjoy recreationally with friends. Unlike their wealthier, more privileged counterparts, however, our clients' marijuana use routinely has life-altering consequences. At minimum, it may lead to an indicated case that remains on their record for up to 28 years, or to it may lead to even more serious consequences, such as the filing of allegations of neglect against them in family court, and may even create a barrier to the return of their children to their care if they have been removed for other reasons.

Sometimes, as with new mothers who test positive for marijuana at the hospital after giving birth, marijuana use is the initial allegation that triggers the filing of a neglect case. More often though, in Brooklyn, marijuana use is raised later in the course of a neglect case, when a parent is required to complete drug treatment for marijuana use as part of their "service plan," which they must complete to get their children home or to close their ACS case. Marijuana use is too often the allegation or alleged safety concern that follows a parent for the longest time – the unfinished issue that delays reunification and drags out state surveillance for years. A parent's ability to achieve total abstinence becomes more important than their commitment to their families and their ability to safely care for their children – due, we believe, to the stigma of marijuana use by Black and Latinx parents. Family Court and ACS often make little to no distinction between recreational or thoughtful use of marijuana by a parent, and the use of drugs that has a harmful impact on children, even though the law specifically prohibits the *misuse*, and not simply the use, of drugs and alcohol.[1]

The vast majority of the people we represent are people of color living in poverty, raising their

[1] Family Court Act Section 1012 specifically defines a "neglected child" as "a child less than eighteen years of age whose physical, mental or emotional condition has been impaired or is in imminent danger of becoming impaired as a result of the failure of his parent or other person legally responsible for his care to exercise a minimum degree of care…by misusing a drug or drugs…" FCA §1012(f)(i)(B); *Nassau County Dep't of Social Servs. ex rel. Dante M. v. Denise J.*, 87 N.Y.2d 73 (1995) (per curiam)(The Court held that"[a] report which shows only a positive toxicology for a controlled substance generally does not in and of itself prove that a child has been physically, mentally or emotionally impaired, or is in imminent danger of being impaired." The Court of Appeals stressed that "[r]elying solely on a positive toxicology result for a neglect determination fails to make the necessary causative connection to all the surrounding circumstances that may or may not produce impairment or imminent risk of impairment in the newborn child.")

children in homeless shelters or public housing, and in highly-policed neighborhoods, making them vulnerable to government surveillance. Similar to the ways in which the possession or use of marijuana may be used as a pretext to "stop-and-frisk" a person based on their race or the neighborhood they live in, suspected or actual marijuana use can be used as a pretext for child welfare involvement, government supervision of a family, and even the removal of children from their home.[2]

Even though it is now generally accepted that recreational or medical marijuana use can coexist with responsible, loving parenting, the people we represent, because of their poverty, race, and the surveillance over their lives, come under harsh and misplaced scrutiny. It is clear that the moral judgment imposed upon our clients surrounding their marijuana use is a direct reflection of class and race-based prejudice.

DRUG TESTING UPON THE BIRTH OF A CHILD

Racial disparities have been well-documented at many points in the health care delivery system, and we know that mothers of color and poor mothers are more likely to be drug-tested in child birth than white mothers, more likely to be reported to child welfare agencies, and more likely to be investigated by the state.[3] Positive drug tests often lead to further invasive investigation, the filing of a family court case, and possibly the removal of children. Our office continues to represent clients who face neglect allegations and the removal of their children due to their marijuana use during, before and even after pregnancy.

Many of the people we represent utilize public and private hospitals that predominately serve low-income patients for prenatal care, labor, and delivery. It is common for our clients and their newborns to be drug-tested at birth, often without their knowledge, without their informed consent, or even despite their explicit refusal. Our understanding is that the Health + Hospitals' (H+H) policy requires verbal consent to drug testing during or after labor, but many people who have been tested at a hospital report that they were not asked permission for the hospital to test themselves or their babies. Drug testing without informed consent is often applied selectively, disproportionately impacting poor women and women of color using government-funded health care,[4] and is out of step with professional standards.[5] This is particularly disturbing because in

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[2] Burrell, Michelle. "Child Welfare Needs to Have It's 'Stop-And-Frisk Moment.' *The New School Center for New York City Affairs*. http://www.centernyc.org/child-welfare-needs-to-have-its. June 27, 2018.

[3] Chasnoff, Ij, Hj Landress, and Me Barrett. "The Prevalence of Illicit-drug or Alcohol Use During Pregnancy and Discrepancies in Mandatory Reporting in Pinellas County, Florida." International Journal of Gynecology & Obstetrics 33, no. 4 (1990): 389. doi:10.1016/0020-7292(90)90575-6.

[4] Open Society Foundations. "Expecting Better: Improving Health Care and Rights for Women Who Use Drugs." https://www.opensocietyfoundations.org/sites/default/files/expecting-better-improving-health-and-rights-for-pregnant-women-who-use-drugs-20181016.pdf (2018), at 8, citing Amnesty International "Criminalizing Pregnancy: Policing Pregnant Women Who Are Using drugs in the USA." https://www.amnesty.org/download/Documents/AMR5162032017ENGLISH.pdf (2017), at 40.

[5] The American Congress of Obstetricians and Gynecologists (ACOG). "Toolkit on State Legislation: Pregnant Women and Prescription Drug Abuse, Dependence and Addiction." https://www.acog.org/-/media/Departments/Government-Relations-and-Outreach/NASToolkit.pdf?dmc=1&ts=20190226T1940529955 ("ACOG policy states that urine drug tests should *only* be used with the patient's consent and to confirm suspected or reported drug use, including for women who present at **hospitals for labor and delivery**.")

our experience hospitals are not using confirmatory testing or the most reliable testing,[6] and there are no drug testing guidelines or requirements for hospitals, as there are in other contexts.

Given the dearth of scientific evidence proving that a person's use of marijuana during pregnancy is harmful to a child,[7] particularly when that child has not also tested positive for marijuana, the choice to test a person for marijuana during labor is in and of itself unnecessarily invasive and may only lead to worse outcomes for the family. As far as we know, there is no standard of care that is different for a newborn who tests positive for marijuana, and a mother's positive test for marijuana does not provide any useful information about a new parent's current ability to care for a newborn.[8] On the contrary, the heightened scrutiny and separation of infants from their mothers after birth that occurs when a mother or child tests positive for marijuana at birth have clear negative consequences to neonatal development.[9] Evidence also shows that routinely testing pregnant mothers and newborns is bad public health policy. It may cause women to avoid seeking prenatal care or other treatment because of a fear that their newborns will be removed. As such, there is no clear medical or child protective justification for testing birthing parents for marijuana.

DRUG TESTING PARENTS AT THE INVESTIGATIVE STAGE WHEN THEY DO NOT HAVE ATTORNEYS

Parents who come into contact with the child welfare system are frequently asked to submit to drug tests during the investigative stage of a case when they have no right to counsel and no access to an attorney for legal advice. Case workers do not advise parents that they have no obligation to take a drug test without a court order. 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. Instead, parents are regularly informed by ACS that if they refuse to submit to a drug test, a negative inference will be made that the test would have been positive. 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 by ACS that they need to complete a drug treatment program and abstain from using marijuana without an assessment of whether the parent's marijuana use is negatively impacting the children. Thus, parents go into substance use disorder treatment programs unnecessarily when they are busy juggling jobs and caring for their children – and taking up spots that are may be sorely needed by people with true substance use disorders.

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[6] ACOG. "Even with consent, urine testing should not be relied upon as the sole or valid indication of drug use. Positive urine screens must be followed with a definitive drug assay…Routine urine drug testing is not highly sensitive for many prescription drugs and results in false positive and negative results that are misleading and potentially devastating for the patient, including accusations of child abuse and neglect."

[7] Connor, et al. "Maternal marijuana use during pregnancy is not an independent risk factor for adverse neonatal outcomes after adjusting for confounding factors." Obstet Gynecol. 2016 Oct;128(4):713-23. doi: 10.1097/AOG.0000000000001649. Available at https://www.ncbi.nlm.nih.gov/pubmed/27607879.

[8] ACOG. "Urine drug tests are not a substitute for verbal, interactive questioning and screening of patients about their drug and alcohol use…Testing does not provide valid or reliable information about harm or risk of harm to children."

[9] Open Society Foundations, at 15.

ACS' TOTAL ABSTINENCE POLICY IS INAPPROPRIATE AND DISPROPORTIONATELY AFFECTS PEOPLE OF COLOR WHO ARE THE PRIMARY TARGET OF THE CHILD WELFARE SYSTEM

In our experience, ACS requests total abstinence from marijuana from the majority of parents regardless of whether that use is recreational or whether there exists any evidence that a parents' use directly impacts their ability to safely care for their children. This is out of step with the requirements of the Family Court Act, which allows for a finding of neglect only where there is proof of *mis*use of drugs, *and* where that *mis*use is directly impacting their ability to provide adequate care or meet children's basic needs [emphasis added].

In our experience, ACS' treatment of marijuana use in child welfare-involved families demonstrates a conflation of use and misuse. Our clients who admit marijuana use or test positive for marijuana even once are usually referred by ACS to participate in rigorous drug treatment programs and/or continue to submit to random requests for drug testing indefinitely. These referrals have a coercive effect before a case has been filed, when the specter of a possible court case or child removal looms. We also see this effect after a case has been filed, when completion of treatment can be a prerequisite to expanded visitation, reunification, and/or ending state surveillance over a family.

Directing users of marijuana to drug treatment programs regardless of the degree and nature of use both misdirects scarce substance use treatment resources and the limited time and resources of our clients. Drug treatment programs have demanding and cumbersome schedules: Depending on the treatment center, parents may be expected to go to treatment several times per week, for several hours each day. Participating in these treatment programs limits our clients' ability to seek and maintain employment, to pursue an education, and to spend needed time with their children.

Underserved communities of color have long been over-policed in the war on drugs. Similarly, in the child welfare system, marijuana prohibition and the insistence on total abstinence results in the systemic separation of poor families and families of color; this stands in stark contrast to the apparent absence of any legal action or drug treatment requirements imposed upon the white male author of an op-ed in *The New York Times* proclaiming the benefits of illegal marijuana use in parenting.[10]

We call on the City Council to increase the transparency and accountability of ACS and H+H in their investigation and reporting of marijuana-related cases; to be a leader in efforts to increase protections for patients by requiring informed, written consent for drug testing; and to call for a clear policy by ACS prohibiting adverse action against a parent for the mere possession or use of marijuana. Ultimately, we believe a culture shift to end the stigmatization and kneejerk condemnation of parents of color who use marijuana or other drugs is needed, and we hope that change could be engendered, in part, by a strong statement against disproportionately enforced and harmful prohibition policies as well as routine drug testing mothers at childbirth.

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[10] Mark Wolfe, *Pot for Parents*, N.Y. TIMES, Sept. 7, 2012 at http://www.nytimes.com/2012/09/08/opinion/how-pot-helps-parenting.html.

RECOMMENDATIONS

Res. 0740-2019 - Possession or Use of Marijuana Does Not Create an Imminent Risk of Harm Requiring Removal

BDS strongly supports this resolution. Current New York law does not allow the possession or use of marijuana to be the sole basis for the removal of the child from a parent, and ACS' policy should reflect this basic legal principle. However, the resolution should also reflect that current law does not allow for the possession or use of marijuana to be the sole basis for a finding of neglect, either. As such, we urge the Council to align this resolution to the law and call upon ACS to draft and implement a policy that the mere possession or use of marijuana does not form the basis of a finding of neglect.

Similarly, we also urge the Council to call on ACS to implement a policy that the possession or use of marijuana alone cannot be the sole basis of an indicated case in the State Central Register or the sole basis to delay reunification of a family. Marijuana should be treated like alcohol – it should only be part of child protective investigation where it is clear that it is being misused to the point that the children are being harmed as a direct result.

A strong and clear statement from the Council and ACS will help us move towards a more equitable system that is better equipped to assist in keeping families safe and together.

Res. 0746 - Regulations for Hospitals on Drug Testing Those Who Are Pregnant or Giving Birth

BDS strongly supports this resolution. We further urge the Council to call on the State Legislature to pass- and the Governor to sign legislation requiring the Department of Health to amend the law to require that all hospitals, both public and private: obtain *informed written consent* before drug testing a patient; use only scientifically sound confirmed drug testing; offer regular, mandatory, comprehensive, and evidence-based training for staff on the effects of parental marijuana use on children; and ensure that patients giving birth and their newborns not be tested for marijuana because there is no medical or public health reason to justify such a test.

Further, rather than wait on the State Legislature, Governor, and the Department of Health to implement urgent and needed policy changes, we call on the Council to take action to require H+H to create and implement these changes now. It is our position that the current H+H policy requiring verbal consent for drug testing is not being implemented or documented in medical records, and is simply insufficient to ensure the privacy of patients or a full and accurate assessment of the risk of harm to a child.

Int. 1426-2019 – Reporting on Investigations Initiated by ACS Resulting from Drug Screenings at Facilities Operated by NYC Health and Hospitals

BDS supports this bill. However, because many of our clients and other low-income parents seek prenatal treatment and give birth at private hospitals, we urge the Council to require ACS to also report on investigations resulting from drug screenings performed at private hospitals. Without this information, this bill would only allow us to see a portion of the impact of hospital drug screenings. We also urge the Council to require reporting regarding the specific hospital that

conducted the test, as well as the specific drug testing method used by the hospital, including whether there was any follow-up or confirmation drug testing completed.

Int. 1161-2018 – Enhanced Reporting on the Child Welfare System

BDS supports this bill and urges the Council to require reporting that disaggregates substance abuse allegations into the specific drug misuse alleged, and that race be a required reporting category as well as ethnicity.

Additional Recommendations

1.) Given the frequent, coercive, and often baseless requests for parents to submit to drug testing during the initial investigation phase of a case, prior to the filing of a petition in court, and therefore, prior to the assignment of counsel for those who cannot afford legal representation, we urge the Council to call on ACS to implement a policy requiring ACS to inform every parent about their right to decline to take a drug test and to abandon their practice of taking negative inferences when parents decline a test. This aligns with parent advocates' request for the Council to develop a Parent Bill of Rights, similar to Miranda warnings that are required during arrest.

2.) With access to legal counsel before a court case is filed, parents with child welfare involvement would have the guidance needed to make informed decisions that would lead to better outcomes. New York City family defender offices have proposed a new and innovative initiative to fund pre-petition legal advocacy and social work assistance, which would reduce unnecessary court filings and family separations. We respectfully urge the City Council to fund this new initiative.

CLIENT STORIES

Included here, please find accounts of our client's cases, representing just a small fraction of families whom we represent who are negatively impacted by ACS and H+H's current policies around marijuana use.

When **Ms. K** went to the hospital to give birth to her daughter, hospital staff told Ms. K that all women giving birth are tested for drugs, so she should just tell them whether she would test positive for marijuana. Ms. K then admitted to using marijuana a couple of days prior. This admission spurred continued questioning and investigation of Ms. K. Ms. K's newborn daughter was then removed and placed in non-kinship foster care, where she remains. Ms. K was asked to complete a substance abuse program and to test negative for marijuana. Ms. K was also required to abstain from drinking as well. Over the course of more than a year, Ms. K took part in a substance use treatment program, which she completed. Ms. K was also required to participate in individual therapy, complete a parenting skills program and an anger management program, and have supervised visitation with her daughter. Ms. K completed all requested services and remains in individual mental health treatment. ACS continued to seek a finding of neglect against Ms. K, and her child remains in foster care.

Ms. G's children were removed from her care due to an unexplained injury to one of the children. After obtaining medical records, it was clear that Ms. G had a reasonable explanation

consistent with the injury. At that point, the children had already been removed from Ms. G's care for several months, and the only barrier to returning the children to her care was her marijuana use. Ms. G's children were only returned to her care once she completed a drug treatment program and consistently tested negative for marijuana. Thus, her marijuana use prolonged reunification of the family by seven months.

Ms. A's case began when ACS was contacted after she and her child tested positive for marijuana at her child's birth. At first, ACS did not file a case against Ms. A, but insisted that she engage in drug treatment for her marijuana use. When Ms. A did not, ACS filed neglect charges against her. When Ms. A did not complete drug treatment after the filing, the Court granted ACS' request to remove Ms. A's three-month old from her care. Ms. A immediately entered an inpatient drug treatment program, where she had to consistently test negative for nearly two months before her children were returned to her care. Ms. A successfully completed the mother-child program and ACS agreed to the dismissal of her case.

When **Ms. P** gave birth to her child, she was very forthcoming with the hospital about having used marijuana occasionally in the past, including a few times during her pregnancy. The hospital then tested Ms. P and her child. Ms. P tested positive for marijuana and her child tested negative. Ms. P was a young mother, but prior to giving birth, she moved to New York to remove herself from a destructive environment, found employment, entered into a mother-child program and shelter, registered for parenting courses, and began GED courses. ACS filed a neglect case against her and due to her marijuana use, ACS sought to place her daughter in foster care. Ms. P's child remains removed from her care in spite of her safe visits with her daughter, because she was not able to complete an inpatient mother-child drug treatment program and continues to use marijuana.

Ms. P and her child tested positive for marijuana at her child's birth. ACS was called and for 16 months, Ms. P engaged in a drug treatment program at ACS' request. When Ms. P continued to recreationally use marijuana, ACS filed allegations of neglect against her, alleging that she failed to voluntarily engage in a drug treatment program, and sought an order that the court granted excluding Ms. P from her home. Ms. P visits with her child nearly every day without any reported safety concerns, but cannot be alone with him, or return to her home, because she continues to use marijuana and has not entered a drug treatment program.

Ms. B's older child was removed from her care, and placed in foster care, due to allegations of excessive corporal punishment. After completing an array of services, Ms. B's contact with her child was limited to supervised visits, and her child's placement in foster care continued for more than two years because she continued to test positive for marijuana. Ms. B's younger child was then removed from her care at birth due to her and her child testing positive for marijuana. Ms. B had to consistently test negative for marijuana for five to six months before her children were returned to her care.

Ms. F tested positive for marijuana at her child's birth which triggered ACS entering her life and filing allegations of neglect against her. ACS recommended that she engage in a parenting course, domestic violence counseling, a drug treatment program, and a mental health evaluation. Daunted by this litany of services, Ms. F decided to arrange for her mother to care for her child. ACS continued to pursue a finding of neglect against Ms. F, and though she visits with her child nearly every day without any reported safety concerns, and continues to plan for her child to

remain with her mother, ACS continues to request that Ms. F complete a drug treatment program for marijuana.

Ms. G and her child tested positive for marijuana when her child was born. A report was called in by the hospital and ACS requested that she complete a drug treatment program, and that she continue to submit to drug tests for nearly two months before filing a neglect petition that included allegations regarding marijuana use. ACS only made one visit to Ms. G's home in this two-month time. ACS continues to request that Ms. G complete a CASAC evaluation, random drug screens, a parenting course, a mental health evaluation, and preventive services. Ms. G uses marijuana to treat her pain from a herniated disc in her back; she believes this is a healthier option than prescription pain medications.

Ms. H was young and inexperienced, and not entirely prepared for motherhood when she gave birth to her first child. When her child was born, she was drug tested at the hospital without her knowledge or explicit consent and she tested positive for marijuana. After a hearing, the Brooklyn family court granted ACS' request to remove Ms. H's newborn from her care. Thankfully, the appellate court disagreed, and permitted Ms. H to keep her newborn in her care. The process of giving birth, immediately being brought to court, anticipating the worst possible outcomes through the course of an emergency hearing, and testifying on her own behalf was a harrowing experience for Ms. H. As a new mother, what she really needed to safely care for her child was meaningful support. ACS ultimately agreed to dismiss Ms. H's neglect case just three months later.

Ms. P drank hemp tea during the course of her pregnancy. At the birth of her fourth child, her newborn tested positive for marijuana. ACS filed neglect allegations against Ms. P, raising previous ACS involvement from nearly 7 years prior, and alleging that her older children were derivatively neglected due to her marijuana use. The children were released to her care but the Court ordered that Ms. P allow ACS to make announced and unannounced visits to her home.

Ms. R was seventeen years old and in foster care herself when she gave birth to her son. Ms. R is open and honest about her ongoing marijuana use and takes steps to ensure that her child is in the care of others – including her group home staff or the child's grandmother – when she uses marijuana. There has been no indication that her marijuana use has in any way affected her ability to safely care for her son. Still, ACS has sought to remove Ms. R's son from her care three times in three months due, in part, to her marijuana use. Ms. R, exhausted by the constant ACS and Court surveillance, has consented to stop using marijuana.

Ms. B's newborn tested positive for marijuana when he was born. ACS became involved, filed neglect allegations against Ms. B, and then asked that she submit to ongoing drug tests, test negative for marijuana, complete a drug treatment program, and engage in mental health treatment. Ms. B continued to dutifully care for her children without any reported safety concerns and cooperate with all recommended ACS mandates. However, ACS would not agree to a dismissal of the case until more than one year after the birth of the child. The ongoing court case and ACS supervision prevented Ms. B from being able to join her family in another state, where she would have had much needed support.

Ms. J's ACS involvement began when she was alleged to have left her 15 year old home alone. ACS insists that Ms. J and both of her teenage children submit to drug tests. While there is no

indication that Ms. J's marijuana use currently interferes with her ability to safely care for her children, ACS requests that Ms. J engage in a drug treatment program and continues to request that her children submit to drug tests, over the objection of their attorney.

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We thank the City Council for your time and attention to these issues, and hope you consider BDS a resource as we continue to work toward fairness in the child welfare system.

If you have any question about this testimony, please contact Daniel Ball at dball@bds.org or (347) 592-2579.

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TESTIMONY

The New York City Council
Committee on General Welfare
Stephen T. Levin, Chair
Committee on Hospitals
Carlina Rivera, Chair

Testimony on the Impact of Marijuana Policies on Child Welfare

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The Legal Aid Society submits this testimony to the Committee on General Welfare and the Committee on Hospitals to share our perspective on the negative impact that marijuana policies, including its criminalization, have on the child welfare system. We thank Chair Levin and Chair Rivera for the opportunity to address this important topic.

Who We Are

The Legal Aid Society is the nation's largest and oldest provider of legal services to low income families and individuals. The Society operates three major legal practices – Civil, Criminal and Juvenile Rights – providing comprehensive legal services throughout New York City. The Legal Aid Society's Juvenile Rights Practice provides legal representation to children who appear before the New York City Family Courts in all five boroughs, in abuse, neglect, juvenile delinquency, and other proceedings affecting children's rights and welfare. Last year, our staff represented some 34,000 children. Our perspective comes from daily contact with children and their families, and frequent interactions with the courts, social service providers, and State and City agencies whose practices impact our clients and their families. In addition to representing many thousands of children each year in trial and appellate courts, The Legal Aid Society pursues impact litigation and other law reform initiatives on behalf of our clients.

Day in and day out, we at The Legal Aid Society zealously advocate for marginalized, disenfranchised and oppressed communities. We know that these injustices are rooted in racial inequities that permeate every part of our legal system, stemming from our history in slavery. The child welfare system is no exception. The government's impulse to insert itself into the lives of children from the homes of racially disenfranchised and impoverished families for the purported benefit of the children has been with us for decades.[1] Any examination of policies and

[1] See Bernstein, Nina, "The Lost Children of Wilder: The Epic Struggle to Change Foster Care," Pantheon Books, 2001. For a summary of this history, see also Jenny Pokempner and Jennifer Rodriguez's article in *Teen Vogue*,

practices in child welfare must be rooted in an understanding of the racial inequities that exist in the child welfare system and involve those directly impacted. Accordingly, we must be ever vigilant that in New York City, where economic inequality is likely unparalleled, the government does not confuse poverty with dangerous parenting.

The Disproportionate Impact of the Child Welfare System on Families of Color

The child welfare system has a profoundly disproportionate impact on families of color in NYC. Black children enter the child welfare system in numbers far greater than their proportion of the general population. While black children represent 24.3% of the city's youth, they make up over 55% of the population in foster care.[2] Black children in NYC are 6 times as likely to be reported to the State Central Registry (SCR) as white children, 8 times as likely to have the report indicated,[3] and 13 times as likely to be admitted into foster care, according to 2014 OCFS data.[4] Hispanic children in NYC are likewise more likely to be involved in the child welfare system when compared to their white counterparts; Hispanic youth in NYC are 5 times as likely to be involved in an indicated case and 5 times as likely to be admitted into foster care.[5]

The vast majority of children entering foster care in New York City and New York State come from the same few neighborhoods, specifically communities facing significant problems of poverty, inadequate services to meet the needs of their residents, low performing schools, higher than average prevalence of health and mental health issues, and substandard housing stock.[6] Oftentimes, those living in poverty have more contact with government agencies and so-called

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"Foster Care in the United States: A Timeline," published May, 31, 2018 and available at https://www.teenvogue.com/story/foster-care-in-the-united-states-a-timeline.

[2] https://ocfs.ny.gov/main/bcm/DMR_Section%20Seven%20of%20Grant%20RFP_2015.

[3] ACS investigates reports of suspected child abuse and neglect made to the SCR involving NYC families. If ACS finds some credible evidence of abuse or neglect, ACS deems the report indicated and it is retained in the SCR.

[4] https://ocfs.ny.gov/main/bcm/DMR_Section%20Seven%20of%20Grant%20RFP_2015.

[5] *Ibid.*

[6] https://ocfs.ny.gov/main/cfsr/data/outcomes/CFSR-Round-3-Wave-4-Outcomes-Packet-20180109.pdf; https://www1.nyc.gov/assets/acs/pdf/data-analysis/2017/CityCouncilReport2017Annual.pdf; https://www1.nyc.gov/assets/acs/pdf/data-analysis/2018/AbuseNeglectInvestByCommDistrictYrs2014To2017.pdf

welfare services, the employees of which are mandated reporters of child abuse and neglect. The higher visibility of these families contributes to the disparate minority representation in the child welfare system.[7] At the same time, essential services are often lacking in predominately Hispanic, African-American and Native American communities across the country. The lack of supportive services for families in these communities compounds the likelihood of being referred to the child welfare system, as early access to such services may prevent the need for state intervention in family life.[8]

The Disproportionate Impact of Marijuana Policies on Families of Color

For decades, the hyper-criminalization of communities, primarily communities of color and low-income areas, has also led to the unfair and vast overrepresentation of Black and Latinx families in New York City in the criminal justice system. These disparities are stark when looking at the NYPD's policing of marijuana in NYC. Ninety-three percent of those arrested by the NYPD for marijuana possession in January-March of 2018 were Black and Latinx. Of the 4,081 people arrested for criminal possession of marijuana, only 287 (7%) were White people, compared to 2,006 (49%) Black people and 1,621 (40%) Latinx people.[9] These numbers are especially troubling as there is no significant difference in the rates of drug use or sale between African American and White people.[10] The over-policing of Black and Hispanic people in NYC contributes to their over-representation in the child welfare system; arrests for marijuana

[7] Center for the Study of Social Policy, "Entangled Roots: the Role of Race in Policies that Separate Families," November 2018, pages 16-17; see also https://www.childwelfare.gov/pubPDFs/racial_disproportionality.pdf
[8] *Ibid.*
[9] https://www.innocenceproject.org/racial-disparities-in-nyc-arrest-data-marijuana-possession/
[10] ACLU, "The War on Marijuana in Black and White," June 2013, available at https://www.aclu.org/files/assets/aclu-thewaronmarijuana-rel2.pdf.

possession frequently result in reports to ACS, even if the marijuana possession charges are not ultimately prosecuted.[11]

The Interplay Between Problematic Marijuana Policies and the Child Welfare System

Racially biased policies and practices relating to marijuana in law enforcement and in the child welfare system are mutually reinforcing and ultimately have a profoundly negative impact on families of color in New York City. Multiple studies have found systemic bias among decision-makers reporting alleged abuse and neglect to child welfare systems.[12] Reports of drug use by mandated reporters like law enforcement and medical personnel in public hospitals to child protective services are more likely to happen to Black parents.[13] Black parents who are reported are then at a higher risk for these reports to be substantiated, by virtue of their race.[14]

In New York, mandated reporters are required to make a report to the State Central Registry (SCR) when they have reasonable cause to believe that a child is being neglected, including parental use of illegal drugs, like marijuana. Even in cases involving what is ultimately recreational marijuana use, ensuing investigations can lead ACS to impose "safety plans" and demand cooperation with preventive rehabilitation services. Failure to comply with these plans puts parents at risk of court involvement and ultimately removal of their children. Even without court involvement, these parents risk placement on the SCR for neglect, which in turn negatively impacts their employment opportunities and corresponding ability to provide a stable environment for their children.[15]

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[11] See https://www.nytimes.com/2011/08/18/nyregion/parents-minor-marijuana-arrests-lead-to-child-neglect-cases.html.
[12] *See* Hill, Robert B., "Synthesis of Research on Disproportionality in Child Welfare," October 2006 at p.18.
[13] Children's Bureau, "Child Maltreatment 2015," January 2017, available at https://www.acf.hhs.gov/sites/default/files/cb/cm2015.pdf.
[14] Dettlaff, Alan et al, "Disentangling: The influence of race, income, and risk on the substantiation decision in child welfare," September 2001.
[15] *See* https://www.nytimes.com/2019/02/25/nyregion/ny-child-abuse-database.html.

New York's mandated reporter requirements generally lead hospitals to file an SCR report if a baby or mother tests positive for illegal drugs at birth, but the state does not regulate when physicians and hospitals can or should conduct such screens.[16] This is concerning because evidence suggests that punitive measures related to positive tests are not applied evenly across race and socioeconomic status. In a landmark study among anonymously drug tested pregnant women, although drug use was found to be similar between African American women and White women, African American women were 10 times more likely to be reported to law enforcement as a result of positive screening results.[17] A Daily News article from 2012 reviewing the testing policies of NYC hospitals uncovered that those which served impoverished sections of the City often required drug testing of all new mothers, while hospitals serving more affluent communities did not.[18] Whether informed consent for these tests is obtained is another key concern. The American College of Obstetricians and Gynecologists guidance states that for drug testing "there is an ethical responsibility to notify patients of [drug] testing and make a reasonable effort to obtain informed consent."[19] The lack of regulations in New York on drug testing mothers and/or babies at birth means that there is no assurance that such consent is obtained.

Particularly disconcerting when looking at marijuana policies in NYC is the lack of scientific research establishing that marijuana use itself has any direct impact on poor parenting practices. Columbia University neuroscientist Carl Hurt, who serves on the National Advisory

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[16] See https://www.guttmacher.org/state-policy/explore/substance-use-during-pregnancy.
[17] Chasnoff IJ, Landress HJ, Barrett ME. The prevalence of illicit-drug or alcohol use during pregnancy and discrepancies in mandatory reporting in Pinellas County, Florida. N Engl J Med 1990;322:1202–6.
[18] *See* http://www.nydailynews.com/new-york/weed-dozen-city-maternity-wards-regularly-test-new-mothers-marijuana-drugs-article-1.1227292.
[19] *See* https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Ethics/Alcohol-Abuse-and-Other-Substance-Use-Disorders-Ethical-Issues-in-Obstetric-and-Gynecologic-Practice. It further notes that "obstetrician–gynecologists have an ethical responsibility to their pregnant and parenting patients with substance use disorder to discourage the separation of parents from their children solely based on substance use disorder, either suspected or confirmed."

Council on Drug Abuse, has spent over two decades studying the neurophysiological, psychological and behavioral effects of recreational drugs, including marijuana. He has testified in Family Courts across the city advocating for children to stay with their parents even following positive tests for marijuana. He posits that "the belief that casual marijuana use impairs your parenting has no scientific basis — and pot use that isn't excessive is on par with having a drink now and again."[20] This is not to say that recreational use never impairs parenting; marijuana can cause temporary impairment, and can lower a person's level of awareness or concentration. Without safeguards, this impairment could be significant enough to pose a risk of harm to a child. But a person can test positive for marijuana days or even weeks after they last used it and thus a positive test does not itself demonstrate impairment or risk of harm at any particular point in time.

Determining when drugs, including marijuana, is a factor in child maltreatment is an ongoing challenge. The National Center on Substance Abuse and Child Welfare conducted an extensive literature review and concluded that there is no evidence-based method to determine whether drug use, including marijuana, contributes to child maltreatment.[21] It noted, however, that research and practical experience points to the frequent co-existence of parental substance use disorders and child maltreatment. The co-existence with substance abuse (not recreational use) points to the ongoing need for unbiased tools to assess the impact of a person's drug use, including marijuana, on their children.

New York's statutory child welfare scheme, in addition to case law, further fuel the problematic marijuana policies and practices in NYC. Family Court Act Article Ten establishes

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[20] *See* https://drcarlhart.com/one-neuroscientist-rethinks-addiction/.

[21] Young, N. K., Nakashian, M., Yeh, S., & Amatetti, S. (2007). Screening and assessment for family engagement, retention, and recovery (SAFERR). HHS Publication No. (SMA) 07-4261. Rockville, MD: Substance Abuse and Mental Health Services Administration.

that repeated use of any illicit drug by a parent is considered prima facie evidence of neglect of their child, unless the parent is also voluntarily and regularly participating in a rehabilitation program.[22] The presumption that any parental use of marijuana necessarily impairs their parenting (unlike any use of alcohol) is grossly overbroad. Further, as the U.S. Department of Health and Human Services' recognizes, "a [positive] drug test alone cannot determine the existence or absence of a substance use disorder," and that "drug tests do not provide sufficient information for substantiating allegations of child abuse or neglect or for making decisions about the disposition of a case (including decisions regarding child removal, family reunification, or termination of parental rights)."[23] Case law in New York regarding parental marijuana use has further served to cement law and practice contrary to scientific research on marijuana use as well as best practices in child welfare.[24] The City Council should call on state legislators to reform the laws to ensure that neither possession nor consumption of marijuana by a parent *alone* is presumed to place a child at immediate risk of harm.

To the credit of the NYC Administration for Children's Services (ACS), it does not bring all, or even most, reported cases involving only parental marijuana use in NYC to Family Court. However, a review of neglect proceedings in 2017 in which The Legal Aid Society was appointed to represent the child(ren) reveals that out of the approximately 1,200 cases that included drug allegations, just over 400 solely involved marijuana. In a significant number of

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[22] Family Ct Act § 1046[a][iii]; *see also,* In re Alexandria S., 105 A.D.3d 856, 21 N.Y.3d 860, 962 N.Y.S.2d 675 (2d Dep't 2013), leave to appeal denied, 21 N.Y.3d 860, 2013 WL 3215530 (2013) (presumption flowing from evidence of drug misuse not rebutted by showing that children were always well kept, clean, well fed and not in danger); In re Sadiq H., 81 A.D.3d 647, 915 N.Y.S.2d 867 (2d Dep't 2011) (father's repeated misuse of drugs established prima facie case of neglect without proof of impairment or specific risk of impairment).

[23] Center for Substance Abuse Treatment. Drug Testing in Child Welfare: Practice and Policy Considerations. HHS Pub. No. (SMA) 10-4556 Rockville, MD: Substance Abuse and Mental Health Services Administration, 2010, available at https://ncsacw.samhsa.gov/files/DrugTestinginChildWelfare.pdf

[24] *See, e.g., In re Shaun H.*, 161 A.D.3d 559, 76 N.Y.S.3d 57 (1st Dep't 2018) (neglect found where respondent smoked marijuana eight to 10 times per week to deal with her stress); *In re Nyheem E.*, 134 A.D.3d 517, 23 N.Y.S.3d 9 (1st Dep't 2015) (neglect finding where mother smoked marijuana on weekends and holidays and testified that she would use drug in home while children were asleep); *In re Elijah J.*, 105 A.D.3d 449, 963 N.Y.S.2d 77 (1st Dep't 2013) (neglect found where mother regularly misused marijuana).

these 400 cases, marijuana use was the only basis for a neglect finding. In addition, our clients in foster care are regularly denied reunification with their parent following the parent's positive test for marijuana. ACS and Family Court judges routinely expect parents to abstain from using all illicit substances, regardless of whether there is evidence of abuse or whether the children were even in their parent's care when they used marijuana.

The New York City Council's Proposed Bills and Resolutions

We support each of the specific resolutions and bills proposed by The New York City Council, and provide additional recommendations for strengthening some of these proposals.

Resolution No. 740

The City Council's Resolution No. 740, calling upon ACS to implement a policy finding that a person's mere possession or use of marijuana does not by itself create an imminent risk of harm to a child warranting the child's removal, is a positive step to protect NYC's children; but this proposal does not go far enough. The resolution should be expanded to prevent mere possession or use of marijuana as a barrier to reunification of child with a parent.

Int. No. 1161 and 1426

The Legal Aid Society supports City Council's bills Int. No. 1161 and Int. No. 1426. Each of these bills would expand the reporting requirements of ACS, providing greater transparency and accountability. At the same time, these bills would enhance the data available to ACS to address problematic practices within NYC's child welfare system.

Resolution No. 746

The Legal Aid Society supports City Council's Resolution No. 746, calling upon New York State to pass legislation requiring the Department of Health to create regulations on drug testing of those who are pregnant or giving birth. Such regulations could serve to minimize

some of the disparate negative impact that the current ad hoc approach brings. However, we would note that mandatory drug testing can have negative consequences. While drug testing can screen for substance abuse disorders, thus facilitating referrals to treatment, screening can often be adequately achieved without the use of testing. Such screening can be preferable since mandatory drug testing can have the unintended effect of keeping those who need treatment away from necessary prenatal care, losing an opportunity for potential intervention.

We would additionally suggest that the City Council call on ACS to implement a policy of not filing neglect cases based solely on a parent's use or possession of marijuana without a clear and articulable showing of the harm that such use or possession has caused or is at risk of causing to the child. Manhattan and Brooklyn district attorneys have enacted similar policies with regard to prosecution of marijuana offenses.[25] We would further suggest that the City Council call on ACS to issue guidelines based on best practice and science detailing the impact a positive test for marijuana should have on decisions regarding a parent's need for services, or child's placement or continuation in foster care. Finally, we would ask City Council to call on ACS to issue a policy that a prior misdemeanor marijuana conviction by itself should not be the basis for a discretionary denial of foster parent certification relatives coming forward to care for children placed into foster care.[26]

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[25] *See* https://www.nytimes.com/2018/09/07/nyregion/nyc-marijuana-laws.html?smid=nytcore-ios-share.

[26] Such convictions are not mandatory disqualifications under state regulation. However, in practice, nearly all criminal convictions result in the discretionary disqualification of applicants to become foster parents, adding to the already difficult task of keeping children with families and in their communities of origin.

The Bronx Defenders | Redefining public defense

New York City Council
Committee on General Welfare jointly with the Committee on Hospitals
Oversight - Impact of Marijuana Policies on Child Welfare
April 10, 2019
Written Testimony of The Bronx Defenders By
Emma S. Ketteringham, Managing Director, Family Defense Practice,
Anne Venhuizen, Supervising Attorney, Family Defense Practice
Jessica Prince, Attorney, Family Defense Practice

My name is Emma Ketteringham and I am the Managing Director of the Family Defense Practice at The Bronx Defenders. The Bronx Defenders has provided innovative, holistic, and client-centered criminal defense, family defense, immigration representation, civil legal services, social work support, and other advocacy to indigent people in the Bronx for more than 20 years. Our staff of close to 400 represents nearly 28,000 people every year and reaches thousands more through community outreach. The primary goal of our model is to address the underlying issues that drive people into the various legal systems and to mitigate the devastating impact of that involvement, such as deportation, eviction, the loss of employment and public benefits, or family separation and dissolution. Our team-based structure is designed to provide people seamless access to multiple advocates and services to meet their legal and related needs.

Our Family Defense Practice has been in place since 2005 and represents parents in child protection and all of the related family court proceedings that arise out of an abuse or neglect case. Since New York City first funded institutional parent representation in 2007, we have represented more than 11,000 parents in the Bronx and helped thousands of children either safely remain at home or safely reunite with their families. Our multidisciplinary staff of more than 50 attorneys, social workers, and parent advocates is assigned to intakes 1,500 new parents each year.

As a holistic defense organization, we have seen the ways that disparate enforcement of marijuana laws has hurt our clients—not only in criminal court, but in family court, housing court, civil proceedings, and in immigration proceedings. We are encouraged that lawmakers are not only seeking to rectify the wrongs that criminal enforcement of marijuana prohibitions have caused in Black and Latinx communities,[1] but are also working to ensure that the child welfare

[1] *Unjust and Unconstitutional: 60,000 Jim Crow Marijuana Arrests in Mayor de Blasio's New York*, Drug Policy Alliance and Marijuana Arrest Research Project, July 2017 (https://www.drugpolicy.org/sites/default/files

system does not cause needless court supervision and family separation based on a parent's use of marijuana. This testimony is intended to assist in that effort by identifying the primary ways that marijuana use is used against parents of color in the child welfare system, and how it often results in parents being added to the State Central Register for Child Abuse and Maltreatment (SCR), unnecessary court filings, prolonged supervision by the Administration of Children's Services (ACS), and traumatic family separation.

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I. The City Council's Marijuana Justice Package Should Address How the Child Welfare System Responds to Use of Marijuana by a Parent.

This January, Governor Cuomo announced his intention to move forward with marijuana legalization in New York State. While marijuana legalization is a step in the right direction, efforts to eradicate the harm to communities caused by marijuana prohibition must address the ways that the child welfare system unjustifiably focuses on marijuana use and the civil penalties that result.

The use of marijuana comes up in a variety of contexts in child welfare cases; the harm it causes is broad and deep.[2] Allegations regarding marijuana use can be the reason ACS indicates a case and places a parent on the SCR limiting their employment options, files a case, opposes unsupervised contact between a parent and a child, requests an extension of supervision of a family, requires a family to engage in services, or rejects a family member available to care for children who must otherwise reside in foster care with strangers. While ACS does not often present marijuana use as the sole allegation in a neglect petition, use of marijuana is often held

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/Marijuana-Arrests-NYC--Unjust-Unconstitutional--July2017_2.pdf) ("*To sum up: In New York City neighborhoods with low rates and numbers of arrests for marijuana possession, and with relatively few Black and Latinx residents, Blacks and Latinx were most of the people police arrested in 2016 for possessing marijuana. And in neighborhoods with high rates and numbers of arrests for marijuana possession, and with high percentages of Black and Latinx residents, nearly all of the people arrested for possessing, marijuana were Blacks and Latinx.*")

[2] Indeed, the child welfare response to drug use generally might overshadow the harm of criminal enforcement of marijuana laws. Research shows that while one in ten people charged with a drug related offense is incarcerated, one in four children are removed by ACS in cases involving allegations of drug use. It is unknown how many of these cases involved the use of marijuana. Additionally, in 2017, 5,916 parents in the Bronx were investigated for allegations of drug use (almost 20% of all investigations), and over 40% of those parents had a case indicated against them—meaning that ACS found that there is "some credible evidence" of the alleged child abuse or neglect and placed the parent on the State Central Registry with far reaching consequences for their employment prospects. It is unknown how many of these investigations were for allegations of marijuana use as opposed to other drugs. See forthcoming report on the NYC child welfare system's response to allegations of drug use by parents, to be published by the NYU School of Law Family Defense Clinic and Movement for Family Power, Feb 2019.

against a parent, along with other allegations, and is invoked at every stage of a family court case to prolong child welfare involvement and, often, family separation.

The child welfare system's response to parents who use marijuana exacerbates the extreme racial disproportionality of the system. Systemic control and separation of families of color is deeply rooted in this country's history.[3] Today, not only are children of color more likely to have contact with the child welfare system, but once involved, they are more likely to be separated from their families, placed with strangers in the foster care system, and remain in care for longer amounts of time.[4] Research has consistently shown that children of all races and ethnicities are equally likely to be abused or neglected; however, children of color are significantly more likely to be represented in the child welfare system than their white peers.[5] In New York City, Black children are more likely to be involved in the child welfare system than white children at each and every stage of the process: Black children are 6.3 times more likely to be involved in a report of abuse or neglect than white children, 7.5 times more likely to be involved in a report indicated by the child welfare agency, and 11.4 times more likely to be placed in foster care.[6] Moreover, in New York City, and New York State as a whole, Black children remain in foster care longer, on average, than white children.[7] Similar to Black children, Latinx children are more likely than white children to be involved in the child welfare system.[8]

Over the last decade, despite shifts away from draconian criminal enforcement, marijuana use, both past and present, is still a frequent basis or contributing factor for the prosecution of child protective proceedings in the family court.[9] Simply changing the law to make it legal to possess and smoke marijuana going forward is not enough to remedy these harms. Any reform must address how the child welfare system responds to the use of marijuana by parents.

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[3] Dorothy E. Roberts, *Prison, Foster Care, and the Systemic Punishment of Black Mothers*, 59 UCLA L. Rev. 1474, 1487 (2012); DeNeen L. Brown, 'Barbaric': America's cruel history of separating children from their parents, WaPo (May 31, 2018), https://www.washingtonpost.com/news/retropolis/wp/2018/05/31/barbaric-americas-cruel-history-of-separating-children-from-their-parents/?noredirect=on&utm_term=.3833ed584ec1; Erin Cloud et al., *Family Defense in the Age of Black Lives Matter*, 20 CUNY L. Rev. 68, 69 (2017).

[4] Jessica Pryce, Wonhyung Lee, Elizabeth Crowe, Daejun Park, Mary McCarthy & Greg Owens (2018): A case study in public child welfare: county-level practices that address racial disparity in foster care placement, Journal of Public Child Welfare.

[5] U.S. Gov't Accountability Office, GAO-07-816, African American Children in Foster Care: Additional HHS Assistance Needed to Help State Reduce the Proportion in Care 8 (2007).

[6] Vajeera Dorabawila & Nicole D'Anna, Disproportionate Minority Representation (DMR) in Child Welfare and Juvenile Justice Systems Report 2014, Part IV, Page 7 (2015).

[7] See id. at 10.

[8] See id. at 7.

[9] https://www.nytimes.com/2011/08/18/nyregion/parents-minor-marijuana-arrests-lead-to-child-neglect-cases.html

A. Marijuana Justice Requires that Hospitals Stop Testing and Reporting Women and Their Newborns to Child Welfare Authorities for Marijuana Use.

Marijuana use is cited to justify charges of child neglect and family separation most often in cases where women have just given birth and are alleged to have used marijuana while pregnant. These women, the vast majority of whom are Black and Latinx, are brought to the attention of child welfare authorities because they are drug tested by medical facilities at birth — often without notice and consent — reported to child welfare authorities, and brought before the family court to answer neglect charges, despite no evidence that they pose a risk to their newborns. Often, they are separated from their newborns during the critical time of maternal-infant bonding, only to be reunited when they are finally assigned an attorney in family court.

Case Study: Marion

The following case illustrates the destructive and unjustified response of the child welfare system to marijuana use. Our client Marion[10] gave birth to a healthy baby girl at a New York City public hospital. Without her knowledge or consent, she was tested for drugs when she gave birth. Hospital staff informed her that she had tested positive for marijuana and that they would be testing her newborn daughter as a result. Marion was not given any medical explanation for why the drug screen was necessary nor the opportunity to refuse. She waited, confused and anxious, for the results. When the urine sample from the infant came back negative for all substances, Marion was discharged home with her newborn.

During the next two weeks, Marion attended to her daughter's every need while her partner worked outside of the home. She attended two well-baby visits and her pediatrician assured her that her baby was healthy and growing appropriately. At the second visit, however, the doctor also informed Marion that the result of a second drug screen had returned positive for marijuana. The doctor informed Marion that because the test was positive for marijuana she was required to call the Statewide Central Register of Child Abuse and Maltreatment (SCR) hotline and report Marion to the authorities, but that Marion should not worry as her daughter was clearly well cared for.

The following evening, on a Friday, two weeks after she had taken her baby home from the hospital, Marion received a knock at the door from an ACS child protective specialist (CPS). As the CPS later reported, the CPS observed Marion's home to be clean and well prepared to care for a baby. She observed the baby to be well taken care of and she had no immediate concerns. She further stated that she did not observe Marion to appear under the influence of any substances during her investigation.

Despite these observations, the CPS informed Marion that she was going to remove Marion's newborn from her care because of the positive marijuana screen. Marion begged the CPS not to remove her baby. When the CPS insisted she had no choice, Marion begged her to

[10]All names used throughout are changed to protect privacy.

wait for the baby's father to return home and to consider having him care for the baby if she could not. At no time did the CPS tell Marion she could speak to an attorney or have an advocate advise her of her rights. The CPS agreed to wait, but informed Marion that she would have to leave the home, and told her that if she returned at all during the weekend and the CPS discovered her there that her baby would be removed and placed in foster care. When the father of the child returned home, CPS quizzed him as to how to change a diaper and how many ounces of milk to feed the baby. Satisfied with his answers, CPS left the baby home with her father and told Marion to leave and appear in Bronx Family Court on Monday.

Marion did as she was instructed. She did not turn to family members for a place to stay because she feared bringing ACS to their homes to remove their children. Having nowhere to go, just two weeks after giving birth, Marion slept on the trains. On Monday she went to Bronx Family Court and was assigned an attorney from The Bronx Defenders. Over ACS's objection, the Family Court allowed Marion to return to her home, finding that she posed no imminent risk of harm to her baby. Even though her child was returned, she will never get this critical bonding time back. What's more, the mere filing of a case places her family under the supervision of the Court and ACS for at least another year, and now Marion is ordered to drug test, and permit contract agencies to inspect her child and home in order to keep her baby.

Marion's story is typical of what we see all too often in the Bronx: unnecessary and unjustified charges of neglect brought against women for testing positive for marijuana after giving birth, with traumatic[11] family separation as a result. Any reform about marijuana use must prevent cases like this one from occurring.

1. **Hospitals Should Not Routinely Test Women Who Give Birth or Their Newborns for the Use of Marijuana.**

Cases based on a woman's use of marijuana while pregnant begin with a drug screen of the mother, the newborn, or both, that is conducted by medical personnel at a hospital, as in Marion's case. In our experience, hospitals do not always obtain a woman's consent, let alone informed consent for the test and often do not even notify the woman that the test is being performed on her or her newborn. When tested, no medical explanation or reason is given or recorded in the medical record for why the test is necessary and no medical treatment is offered to or performed on the woman or newborn if the test is positive for marijuana.

Despite the fact that hospitals routinely drug test, there is no law in New York that requires a hospital to drug test a pregnant woman, a woman giving birth, or her newborn. While eight states have enacted laws that require medical professionals to drug test pregnant women when drug use is suspected, New York wisely has not enacted such a statute.[12] Such an approach, as discussed below, undermines maternal fetal and child health. A bill providing for the toxicology testing of newborns and the reporting of positive tests was proposed in the State

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[11] Vivek S. Sankaran & 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, 211 (2016)

[12] https://www.guttmacher.org/state-policy/explore/substance-use-during-pregnancy (as of Feb. 1, 2019)

Assembly in each of the past two legislative sessions, and did not make it out of committee.[13] Nor does any federal law require drug testing of pregnant women.[14]

Drug testing in this manner is inconsistent with the most recently available written policy of the Health and Hospital Corporation (HHC).[15] HHC's policy does not provide for required toxicology testing in the prenatal and postpartum contexts; instead it identifies ten risk indicators that may be considered in determining whether to test.[16] The policy also provides that:

> The medical provider must inform the mother if a toxicology test is necessary and obtain her verbal consent. The provider at the same time should explain to the mother how the results of the toxicology test will be used for her medical care and that of her unborn or newborn child. All toxicology test results must be shared with the patient. If the mother refuses to give verbal consent for testing, this refusal will be documented in her medical record. The medical provider will not conduct testing without the mother's consent. **Note: A positive toxicology test result is not an indication to report to the State Central Registry of Child Abuse and Maltreatment unless there is a concern regarding the safety of other children in the home.**[17]

Our experience is that these directives and guidelines are consistently ignored. To our knowledge, hospitals have different guidelines for when to test and there is little to no oversight by HHC to ensure that testing is not done in a manner that contravenes their policy, done solely for investigative reasons, and in a manner that protects against racial disparities in who is tested and who is reported. This is why The Bronx Defenders supports Resolution 0746 as it calls on New York State to pass legislation requiring the New York Department of Health to create clear and fair regulations for the drug testing of pregnant women and for pregnant women to be informed of their rights prior to testing. Specifically, we recommend that the City Council support the enactment of Assembly bill 5478, with the amendment to make it clearer that it apply to postpartum women and their newborns and require notice and clear consent from a pregnant or postpartum woman prior to drug testing her or her infant.

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[13] Assembly Bill A5369 (Feb. 8, 2017); Assembly Bill A9297 (Feb. 16, 2016).

[14] The Child Abuse and Prevention Act (CAPTA) is the key federal legislation affecting child abuse and neglect. CAPTA does not require states to drug test newborns for drugs. It requires only that states have policies in place to notify child welfare agencies of babies who are "affected by substance abuse," affected by "withdrawal symptoms," or having Fetal Alcohol Withdrawal Syndrome. The law specifically does not require states to define child maltreatment as including babies exposed to drugs or require that it be a child welfare agency that is notified. See Understanding CAPTA and State Obligations, National Advocates for Pregnant Women, (September 18, 2019).

[15] Operating Procedure memo. HHC Operating Procedure 180-8: Corporate Policy for Urine Toxicology Testing in the Pregnant Woman during the Antepartum Period, Labor and Delivery and Postpartum.

[16] Id. at 2.

[17] Id. at 3.

2. Hospitals Should Not Report a Positive Toxicology of a Newborn or Mother for Marijuana to Child Welfare Authorities Absent Other Indications of Neglect.

If a postpartum toxicology screen is positive for marijuana, the consequence is that medical professionals call the SCR maintained by the Office of Children and Family Services (OCFS) to report child maltreatment. If the report is accepted by the SCR, it is transmitted to ACS and ACS commences an investigation. In 2017 in the Bronx, 462 mothers were investigated for drug use while pregnant as a result of calls to the SCR, and almost 70% of these mothers had investigations indicated against them.[18] It is unknown how many women overall were drug tested by medical facilities in the Bronx, how many tested positive for marijuana, and how many or what proportion of the women who tested positive were reported to child welfare authorities.

New York law does not require reporting to the SCR a positive drug test of a mother or newborn at birth. Although twenty-five other states have enacted such laws, New York wisely has not enacted such a requirement.[19] The New York Social Services Law provides that mandated reporters must make a report "when they have reasonable cause to suspect that a child coming before them in their professional or official capacity is an abused or maltreated child." SSL § 413(1)(a). The law has been clear for more than two decades that without more, neither a positive toxicology for an illegal drug (whether a newborn's or expectant mother's), nor a parent's admission of past drug use, is sufficient to establish child neglect.[20] Without fact-specific evidence that a mother's use of marijuana places her child at risk, there is little to no basis for a reasonable suspicion of child maltreatment.[21]

After a report is made to the SCR, ACS has 60 days to investigate the allegations and determine whether the allegation is substantiated. If ACS determines, by finding some credible evidence, that the report is substantiated, the report will be "indicated" and the parent is placed on the SCR until the parent's youngest child turns 28. Placement on this list can mean that a parent is prevented from being hired or loses her employment, as many employment

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[18] "Advanced copy of research report on the NYC child welfare system's response to allegations of drug use by parents, to be published by the NYU School of Law Family Defense Clinic and Movement for Family Power, Feb 2019.

[19] https://www.guttmacher.org/state-policy/explore/substance-use-during-pregnancy (as of Feb. 1, 2019).

[20] *See 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" (citing *In re Stefanel Tyesha C.*, 556 N.Y.S.2d 280, 282–83 (1990)).

[21] Terplan et al. Prenatal Substance Use: Exploring Assumptions of Maternal Untness. Substance Abuse: Research and Treatment 2015:9(S2) 1–4 doi: 10.4137/SART.S23328.

opportunities require SCR clearance, including jobs working with children, custodial or administrative jobs in hospitals and schools, and home health aide positions. In addition, once on this list, it is difficult to be an alternate caregiver for related children should that become necessary in the future. In this way, placement on the SCR can have an impact for generations. The SCR disproportionately affects low income women of color — creating economic instability for families and furthering income inequality along racial lines in our city. Indeed, only 6% of parents with indicated cases are white.[22]

Nearly 27,000 new reports are added to the SCR each year. It is unknown how many parents are placed on this list for the use of marijuana during pregnancy or otherwise. The City Council should require ACS to report on how many parents are on the SCR due to marijuana use. Those parents who are on the SCR for marijuana use should have their records amended and sealed immediately. This is why we recommend that the City Council pass a resolution recommending that New York State pass legislation that would require greater transparency about the SCR and automatically and retroactively amend and seal the records of anyone on the registry because of marijuana use.

3. ACS Should Stop Filing Cases and Removing Children Based on Allegations of Marijuana Use During Pregnancy.

When ACS investigates a parent, it then decides whether to close a case, offer the family preventive services or to file a case in family court and either seek court supervision or a removal of the child to foster care. In a case that involves allegations of marijuana use, the preventive services might include supervision of the home, parenting classes, drug testing, an evaluation of whether a parent requires drug treatment, or a referral to drug treatment. Although these services are labeled "voluntary" by ACS and parents can refuse in theory, parents are under extreme pressure to comply with ACS's demands regardless of whether they believe they need treatment or whether their children are at risk because the consequences of refusing to attend are often that ACS will file the case in family court. Families often comply with unnecessary demands and services out of fear of ACS and escalating the situation.

If ACS files a case, ACS might decide to remove a child from his parents. ACS has broad discretion in making these decisions and it is unknown how many families with allegations of marijuana use are brought to court as compared to how many families are offered preventive services in the community, or what factors are considered by ACS in making the decision. We know that filings of cases seeking court ordered supervision have increased by 30% from 2006 to 2014,[23] and ACS seeks court permission to supervise families in 5,500 new cases per year.[24]

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[22] Strengthen Families by Alleviating Collateral Consequences of Reports to the State Central Register, PLAN (May 2018).

[23] Abigail Kramer, Center for New York City Affairs, Is Reform Finally Coming To New York City Family Court?, at 17 (2016) available at http://www.centernyc.org/s/CWW-Is-Reform-Finally-Coming-to-Family-Court-p0wx.pdf

[24] New York City Administration for Children's Services, *Assessment of New York City Administration for Children's Services Safety Practice and Initiatives,* at 24 (prepared by Casey Family Programs, May 2017) www1.nyc.gov/assets/acs/pdf/testimony/2017/NYCACSAssessmentReportMay2017.pdf

ACS does not report specifically on how many cases it files that involve allegations of marijuana use or how many cases involving marijuana use are maintained as preventive cases.

Family separation, in the context of a newborn, can take several forms. The baby might be removed from the mother *after* being discharged home by the hospital. ACS might require the parent alleged to have used marijuana to leave her home, like in Marion's case, and leave the baby in the care of the other parent. The baby might also be held at the hospital on a so-called "social hold" and ACS will petition the court for placement in foster care. Data is unavailable regarding how many newborns and children are separated from their families based on allegations of marijuana use. It is unknown how many newborns are removed prior to a case being filed in court on a purported emergency basis, as in Marion's case. It is also unknown how many applications ACS makes to the family court to remove newborns and children based on marijuana use and how many of these are granted and how many are denied by the court. It is important that ACS be required to report on these numbers. While ACS has stated publicly that they do not separate children from a parent or file a case against a parent based on a parent's use of marijuana, this is not our experience on the front lines. It is critical that ACS be required to report on marijuana cases and that the data be disaggregated by race, gender, and zip code so that ACS's response to parents who use marijuana is transparent and fully understood.

Regardless of how separation is achieved, the disruption in maternal infant bonding and the consequences are profound. This is why The Bronx Defenders supports Resolution 0740 as it calls upon ACS to implement a policy that a person's mere possession or use of marijuana does not by itself result in family separation. We further recommend that the resolution be expanded to also require ACS to adopt a policy that mere possession of marijuana without any indicia that a child is neglected does not by itself result in the filing of a neglect petition for court ordered supervision or result in the rejection of family resources for children who must otherwise enter foster care.

Moreover, the definition of neglect provided in the Family Court Act does not support the filing of a case against a parent in family court based on a positive toxicology for marijuana. The Family Court Act specifies that neglect can be found based on a parent failing "to exercise a minimum degree of care" by "misusing a drug or drugs," a standard that cannot be met based on a single positive toxicology for marijuana.[25] The Family Court Act also provides that neglect can be found based on "proof that a person repeatedly misuses a drug or drugs or alcoholic beverages, to the extent that it has or would ordinarily have the effect of producing in the user thereof a substantial state of stupor, unconsciousness, intoxication, hallucination, disorientation, or incompetence, or a substantial impairment of judgment, or a substantial manifestation of irrationality."[26] Again, this standard cannot be met based on a single positive toxicology. Twenty-three states have laws that define a mere positive toxicology at birth as child neglect.[27] Here too, New York wisely has chosen not to enact such a statute, and a neglect finding may not be based on drug use alone but on drug misuse, and evidence that a child has been harmed or is

[25] Family Court Act 1012(f)(i)(B)

[26] Family Court Act 1046(a)(iii)

[27] https://www.guttmacher.org/state-policy/explore/substance-use-during-pregnancy

at risk of harm *because of* the alleged drug misuse.[28] See below for a discussion of why New York's law is in line with the public health consensus.

Rarely do cases that involve a positive toxicology for marijuana at birth go to trial. ACS regularly offers adjournments in contemplation of dismissal (ACDs), essentially deferred dismissals, in these cases, pursuant to Family Court Act §1039. An ACD is an order issued on the consent of the parties in which they agree to certain terms and conditions, including ACS supervision for a period of time up to a year, after which the neglect petition is dismissed. A requirement that the parent submit to regular drug testing and not test positive for marijuana is almost always a term of an ACD in a case that involves marijuana use. There is tremendous pressure on the parent to accept an ACD when offered. Given the significant delay experienced in family court, often the time that it will take for the case to go to trial is far longer than the supervision period with an ACD. As a result, allegations are rarely tested at trial, and ACS is not required to provide any proof for its assertion that marijuana use during pregnancy is harmful, much less present scientific evidence through expert testimony to support its allegation that marijuana use during pregnancy causes harm. The result of proceedings against women who give birth after having used marijuana, a substance the city has decriminalized and the state has now decided to legalize, is thus to impose enormous stress on the family, threaten family separation and to place the family under extended surveillance.

B. Ending Routine Drug Testing and Reporting Women Who Use Marijuana During Pregnancy Is a Step Toward Addressing the Racial Disparities in the Child Welfare System.

Similar to stop and frisk practices, the "test and report" practice of hospitals and child welfare authorities reveals extreme racial disparities. Despite similar or greater rates of drug use among white women, African-American women are ten times more likely to be reported to child welfare for a positive drug test.[29] 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."[30] A 2010 study of a hospital in Rochester demonstrated that despite race-blind testing guidelines, the hospital tested and reported greater numbers of women of color regardless of whether they met guidelines.[31] Other hospitals had similar results.[32] This evidence suggests and what we have seen

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[28] *Dante M.*, 87 N.Y.2d at 78-79

[29] The Guttmacher Report on Public Policy, State Responses to Substance Abuse Among Pregnant Women, (December 2000, Vol. 3, No. 6)

[30] Terplan, Cannabis and pregnancy: Maternal child health implications during a period of drug policy liberations, 104 Preventative Medicine 46, Abstract (2017)https://www.nydailynews.com/new-york/weed-dozen-city-maternity-wards-regularly-test-new-mothers-marijuana-drugs-article-1.1227292#ixzz31hXS2sUE

[31] Ellsworth MA, Stevens TP, D'Angio CT. Infant race affects application of clinical guidelines when screening for drugs of abuse in newborns. Pediatrics. 2010;125(6):e1379–e1385.

[32] Brenda Warner Rotzoll, Black Newborns Likelier to be Drug-Tested: Study, Chicago Sun-Times, Mar. 16, 2001 (noting that "[b]lack babies are more likely than white babies to be tested for cocaine and to be taken away from their mothers if the drug is present, according to the March issue of the Chicago

over the past decade in the Bronx is that great racial disparities exist in who is tested and who is reported as child abusers based on the use of marijuana.

It is unknown how many women have been drug tested by New York City hospitals and how their guidelines for who to test are administered. This is why we support Initiative 1426 as it calls upon ACS to report on investigations initiated by health facilities and include information about the subjects of the reports, including the ethnicity of the subject of the report. We suggest that it be expanded to all health facilities rather than just those facilities managed by HHC and that it be amended to require ACS to report on the race of each patient, as well as whether the infant was separated from his or her mother by the hospital or by ACS as a result of a positive drug test.

C. Ending the Practice of Drug Testing Women and Their Newborns and Reporting Those Who Test Positive for Marijuana Is Better for Maternal Fetal Health and the Well Being of Children.

The child welfare system's purpose is to protect children from harm. Charging women who used marijuana during pregnancy with child neglect does not serve this purpose and, as discussed below, has harmful consequences for maternal-fetal health and child well-being. Rather than serving the interest of children, the practice is based on the inflammatory rhetoric of the war on drugs and the resulting negative narrative of Black motherhood and does great disservice to children, families and communities.

For nearly two decades, the popular press was full of highly prejudicial and often inaccurate information about the effects of in-utero drug exposure. In 1986, when crack cocaine began to attract substantial media attention, six prestigious national news magazines and newspapers had featured over one thousand stories about crack: "Time and Newsweek each ran five 'crack crisis' cover stories . . . . [T]hree major network television stations ran 74 stories about crack cocaine in six months. . . . . Fifteen million Americans watched CBS' prime-time

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Reporter"); Troy Anderson, Race Tilt in Foster Care Hit; Hospital Staff More Likely to Screen Minority Mothers, L.A. Daily News, June 30, 2008. Another study concluded that "Black women and their newborns were 1.5 times more likely to be tested for illicit drugs as nonblack women in multivariable analysis." Kunins et al, The Effect of Race on Provider Decisions to Test for Illicit Drug Use in the Peripartum Setting. Journal of Women's Health (2007);16(2):245–255 available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2859171/pdf/nihms-182195.pdf

documentary '48 Hours on Crack Street.'"[33] This hype, that built on pre-existing stereotypes of Black motherhood went largely unchallenged.[34]

But media hype and common knowledge are not the same as scientific and medical evidence. The media has attempted to undo the harm of its earlier reporting on drugs and motherhood,[35] with the New York Times most recently admitting that "[n]ews organizations shoulder much of the blame for the moral panic that cast mothers with crack addictions [during the 1980s and 1990s] as irretrievably depraved and the worst enemies of their children[36] Most importantly, starting in 2004, leading doctors and researchers in the field of prenatal exposure to illegal drugs have attempted to set the record straight.[37]

The scientific literature of today uniformly acknowledges that any evidence of the impact of prenatal exposure to marijuana on fetal or child development is inconsistent and therefore inconclusive.[38] Several researchers have found no correlation between maternal marijuana

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[33] Laura Gómez, Misconceiving Mothers: Legislators, Prosecutors, and the Politics of Prenatal Drug Exposure 14 (1997) (reporting that without knowing that cocaine was used by their mothers, clinicians could not distinguish so-called crack-addicted babies from babies born to comparable mothers who had never used cocaine or crack). See also John P. Morgan & Lynn Zimmer, The Social Pharmacology of Smokeable Cocaine Not All It's Cracked Up to Be, in Crack In America: Demon Drugs And Social Justice 131, 152 (Craig Reinarman & Harry G. Levine eds., 1997); Ruth Rose-Jacobs et al., Do "We Just Know?" Masked Assessors Ability to Identify Children with Prenatal Cocaine Exposure, 23 Devel. & Behav. Pediatrics 340 (2002).

[34] See Dorothy Roberts, Unshackling Black Motherhood, 95 Mich. L.R. 938 (1997); Gómez, supra note 16; Morgan & Zimmer, supra note 16.

[35] Maia Szalavitz, The Demon Seed That Wasn't: Debunking the "Crack Baby" Myth, City Limits Monthly, March 2004; Barry M. Lester et al., Data Base of Studies of Prenatal Cocaine Exposure and Child Outcome, 27 J. Drug Issues 487 (1997) (concluding that knowledge about the existence or extent of effects of prenatal cocaine exposure on child outcome was limited, scattered, and compromised by methodological shortcomings). In 2009 the New York Times tried to set the record straight in Susan Oakie, The Epidemic That Wasn't, N.Y. Times, Jan. 27, 2009, at D1, available at http://www.nytimes.com/ 2009/01/27/health/27coca.html, as did the Washington Post in 2010 in Theresa Vargas, Once Written off, 'Crack Babies' Have Grown into Success Stories, Washington Post, April 13, 2010, http://www.washingtonpost.com/wp-dyn/content/article/2010/04/15/AR2010041502434.html

[36] "Slandering the Unborn," The New York Times, Editorial, December 28, 2018.

[37] Open Letter to the Media by David C. Lewis et al., Physicians, Scientists to Media: Stop Using the Term "Crack Baby" (2004).

[38] See e.g. David M. Fergusson et al., Maternal use of Cannabis and Pregnancy Outcome, 109 BJOG: Int'l J. Obstetrics & Gynecology 21, 21-22 (2002); Peter A. Fried et al., Growth of Pubertal Milestones during Adolescence in Offspring Prenatally Exposed to Cigarettes and Marijuana, 23 Neurotoxicology and Teratology 431, 432 (2001); Peter A. Fried & Andra M. Smith A Literature Review of the Consequences of Prenatal Marihuana Exposure: An Emerging Theme of Deficiency in Aspects of Executive Function, 23 Neurotoxicology and Teratology 1, 8 (2001); Dallas English et al., Maternal Cannabis Use and Birth Weight: A Meta- Analysis, 92 Addiction 1553, 1558-1559 (1997); Melanie C. Dreher et al., Prenatal Marijuana Exposure and Neonatal Outcomes in Jamaica: An Ethnographic Study, 93 Pediatrics 254, 254-256 (1994).

consumption and pregnancy outcomes.[39] Other studies have found a correlation between maternal marijuana use and small negative effects on birth weight or certain developmental markers. For example, one study indicated a possible correlation between marijuana smoking and a decrease in birth weight, although the author and others recognized no correlation after correcting for confounding factors, such as tobacco smoking and poverty.[40] Some researchers have found some slight beneficial correlation with birth weight or infant development.[41] In contrast to heavy cannabis use, occasional use of cannabis before or during pregnancy did not have detectable adverse effects on birth weight, and appeared to increase mean birth weight, although it was not statistically significant. Other studies have found no detectable or consistent increase in the rate or severity of birth defects associated with marijuana use during pregnancy.[42] Peter Fried, one of the most published researcher in this field has acknowledged that any definitive statement of the consequences of prenatal exposure to marijuana would be "problematic, presumptuous, and foolhardy."[43]

Despite these newer more carefully constructed studies, the non-scientific medical misinformation regarding the effect of drug use during pregnancy shaped the child welfare response we know today; one that is based on the "mythology of severe risk" of fetal harm from drug use during pregnancy.

None of these facts are meant to suggest that prenatal exposure to illegal drugs is benign. The current scientific evidence and medical consensus, however, suggests that the risks presented by the use of illegal substances, including marijuana, during pregnancy are no greater than risks associated with many other conditions and activities common in the lives of all people. Years of carefully constructed evidence based research conclude that no scientific basis exists for presuming that prenatal exposure to marijuana will inevitable adversely affect the newborn and does not support the practice of drug testing postpartum women, referring them to child welfare authorities, charging them with child neglect, and dissolving their families.

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[39] See e.g., Fried et al., supra, at 436; Susan J. Astley et al., Analysis of Facial Shape in Children Gestationally Exposed to Marijuana, Alcohol and/or Cocaine, 89 Pediatrics 67, 67-77 (1992).

[40] Fergusson et al., supra, at 23-26. Dreher et al., supra, at 254-60; Katherine Tennes, Effects of Marijuana on Pregnancy and Fetal Development in Human, NIDA Res Monogr. 48-60 (1985); Fergusson et al., supra.

[41] Dreher et al., supra, at 254-60; Tennes, supra; Fergusson et al., supra, at 25.

[42] See, e.g., Albert J. Tuboku-Metzger et al., Cardiovascular Effects of Cocaine in Neonates Exposed Prenatally, 13 American J. of Perinatology 1 (1996) (study of chronic cocaine use among pregnant subjects finding no direct effects on the health or development of newborns). See also Mishka Terplan & Tricia Wright, The Effects of Cocaine and Amphetamine Use During Pregnancy on the Newborn: Myth Versus Reality, 30 Journal of Addictive Diseases 1-5 (2010)(review article concluding that no "well-designed cohort studies" or "systematic reviews...have shown an association with cocaine and anomalies"); Charles R. Bauer, Acute Neonatal Effects of Cocaine Exposure During Pregnancy, 159 Arch Pediatric Adolescent Med. 824-834 (2005)(study of newborn infants prenatally exposed to cocaine finding no "abnormal anatomic outcomes"); Rose-Jacobs et al., supra note 16.

[43] Affirmation on file at The Bronx Defenders.

Physician reporting requirements also put healthcare providers in an ethical bind by pitting them against the interests of their patients and discouraging women from seeking prenatal care, putting both mothers and babies at risk. The American College of Obstetricians and Gynecologists (ACOG) has been on record in opposing the requirements since they were introduced. In its most recent statement on the issue, ACOG explains:

> Although legal action against women who abuse drugs prenatally is taken with the intent to produce healthy birth outcomes, negative results are frequently cited. Incarceration and the threat of incarceration have proved to be ineffective in reducing the incidence of alcohol or drug abuse. Legally mandated testing and reporting puts the therapeutic relationship between the obstetrician-gynecologist and the patient at risk, potentially placing the physician in an adversarial relationship with the patient. In one study, women who abused drugs did not trust health care providers to protect them from the social and legal consequences of identification and avoided or emotionally disengaged from prenatal care. Studies indicate that prenatal care greatly reduces the negative effects of substance abuse during pregnancy, including decreased risks of low birth weight and prematurity. Drug enforcement policies that deter women from seeking prenatal care are contrary to the welfare of the mother and fetus.[44]

ACOG specifically recommends that there be no civil penalties and the threat of child removal as a result of drug screens for marijuana.[45]

Moreover, the response of drug testing and reporting women and their newborns makes them vulnerable to family separation, which is well known to be harmful to children. As the Federal Government's Children's Bureau Child Welfare Information Gateway emphasizes, "Removing children from their families is disruptive and traumatic and can have long-lasting, negative effects."[46] The UC Berkeley Department of Psychology summarized the research[47] as follows:

> Psychological research indicates that forced separation of families, especially the separation of young children from their primary caregivers, carries enormous risks of severe and potentially irreparable harm. Forced separation may lead to acute trauma,

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[44] 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).

[45] American College of Obstetricians and Gynecologists, Committee on Obstetric Practice, *Marijuana Use During Pregnancy and Lactation*, Committee Opinion 722, (Oct. 2017).

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

[47] The research is also detailed and summarized in Vivek Sankaran and Christopher Church, "Easy Come, Easy Go: The Plight of Children Who Spend Less than Thirty Days in Foster Care." 19 UPenn. J. of Law & Social Change, 207, 211-12 (2016). Available at: https://scholarship.law.upenn.edu/cgi/viewcontent.cgi?referer=&httpsredir=1&article=1197&context=jlasc.

> which can trigger increased vulnerability to mental illnesses, including depression, anxiety, and posttraumatic stress disorder, and can impair children's neurological, social, and cognitive development. Long-term outcomes known to be associated with childhood trauma include substance misuse, depression, suicide, and poor physical health.[48]

While there are undoubtedly cases where the harm of remaining in the home would outweigh the harms of separation, there is no basis whatsoever for treating a parent's use of marijuana alone as justifying the decision to knowingly inflict these significant harms on a child. Indeed as one expert has noted, "even in environments where cannabis is legal, pregnant women may end up involved with Child Protective Services. In states where substance use is considered child abuse this may be especially catastrophic. Above all, care for pregnant women who use cannabis should be non-punitive and grounded in respect for patient autonomy."[49]

These harms are even more significant for children removed from their mothers at or soon after birth. Studies in the context of prison nurseries have observed that "[p]rison nurseries remove separation created by maternal incarceration as a threat to a child's development, at least during early infancy."[50] One study thus 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. Separation may damage a developing attachment, thus increasing the likelihood of poor developmental outcomes."[51] This research confirms the intuitive point that children do better when they remain with their mother at birth when they can first develop secure attachments.

In fact, the removal of a child from the parent harms not only that child, but threatens to harm children born after the removal. A study released just this week and published in the Canadian Medical Association Journal concludes that "[w]omen whose first child was placed in out-of-home care had more than twice the rate of inadequate care during the pregnancy of their second child than women whose first child was not placed (33.0% v. 13.4%)." The study notes that "[a]mong mothers whose first child was placed in out-of-home care, the odds of inadequate prenatal care were not affected by the timing of the placement of the first child or by the mother's reunification status with her first child."[52] In other words, the removal of the first child

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[48] "Psychology Department members cite research against family separations." Available at https://blogs.berkeley.edu/2018/07/12/psychology-department-members-cite-research-against-family-separations/

[49] Terplan, Cannabis and pregnancy: Maternal child health implications during a period of drug policy liberations, 104 Preventative Medicine 46, Abstract (2017).

[50] Byrne MW, Goshin LS, Joestl SS. Intergenerational transmission of attachment for infants raised in a prison nursery. Attachment & Human Development. 2010; 12:375–393

[51] Goshin, L. S., Byrne, M. W., & Blanchard-Lewis, B. (2014). Preschool outcomes of children who lived as infants in a prison nursery. The Prison Journal, 94(2), 139–158.

[52] E. Wall-Wieler et al., Prenatal Care Among Mothers Involved with Child Protection Services in Manitoba: A Retrospective Cohort Study, CMAJ February 25, 2019 191 (8) E209-E215. Available at: http://www.cmaj.ca/content/191/8/E209.

is associated with the tremendous disparity in inadequate care, not whether or not that child is in care at the time of the second pregnancy. The authors observe that "previous research has identified a fear of detection or involvement with child protection services as an important barrier for at-risk pregnant women, potentially leading to disengagement from, avoidance of or delayed presentation to prenatal care. We expect this fear to be intensified for pregnant women who had their first child taken into care by child protection services because they may fear this happening again." This observation is consistent with our experience in the Bronx.

In addition to harms to maternal-fetal health, children and families, child welfare involvement harms entire communities that last for generations.[53] It is critical for families and communities that marijuana reform address the consequences of the child protection response of "test and report" that have been experienced by communities of color for decades.

II. The Child Welfare System Uses Parental Marijuana Use as Justification for Numerous Intrusions into a Family's Life

Outside of the context of pregnancy, ACS and family courts often use a parent's use of marijuana as a justification for further intrusions in a family's life. While marijuana use is often listed as a neglect allegation, it can also be the basis for initiating an investigation, supervising a family for longer periods of time, rejecting relatives who offer to be resources for children who are separated from their parents, limiting visitation or separating a family, even when marijuana use is not an official allegation against the parent. Once a parent has child welfare involvement, ACS and the family court will base their many decisions about the family in part on a parent's marijuana use. These decisions negatively impact children, as they increase the possibility of removal, system involvement, and rejection of relatives. In our capacity as counsel to thousands of parents every year, The Bronx Defenders has witnessed the many, often insidious, ways the system rationalizes intrusion into family life because of marijuana use.

A. ACS Should Adopt A Policy Not to File Cases for Civil Child Neglect Based on Allegations of Marijuana Use Where There is No Other Indicia of Neglect.

As described above, a significant number of cases that are based solely on a parent's marijuana use involve allegations that a baby or mother tested positive for marijuana at the baby's birth. ACS also files many cases alleging marijuana use outside the confines of pregnancy. In these cases, ACS requests services relating to marijuana use, even when there is no evidence of any impact of the parent's marijuana use on his or her parenting or children. Too

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[53] *See also* Paul Chill, Burden of Proof Begone: The Pernicious Effect of Emergency Removal in Child Protective Proceedings, 41 FAM. CT. REV. 457, 459 (2003) ("Members of affected families may suffer enduring harm psychologically, financially, and in countless other ways from the stresses of removal and its aftermath (leading to divorce, job loss, etc.)"); Stephanie Clifford & Jessica Silver-Greenberg, Foster Care as Punishment: The New Reality of 'Jane Crow', N.Y. TIMES (July 21, 2017), https://perma.cc/6A3T-WPLH(discussing research that children removed and sent to foster care had higher delinquency rates, teen birthrates, a higher likelihood of going to prison as an adult, and lower earnings).

often, there is little to no inquiry into the nature of the parent's marijuana use and whether the use actually impacts parenting. As such, ACS's requests for services relating to marijuana use often fail to be tailored to the needs of the family and the child safety issues identified, assuming they exist. This is why The Bronx Defenders supports resolution 0740 because it calls upon ACS to adopt a policy not to separate a child from his or her parent based on marijuana use alone. Because court ordered supervision and conditions, including services, for families to stay together are often experienced as stressful and invasive and often fail to actually contribute to a family's well being, we would recommend that this resolution be expanded to call upon ACS to adopt a policy that it not file a case for court ordered supervision of a family based on marijuana use alone as well.

- For example, one client told ACS that she smoked marijuana to deal with her anxiety. ACS filed a neglect petition against her, alleging that she neglected her children because she did not go to an evaluation with a CASAC (credentialed alcoholism and substance abuse counselor) that ACS scheduled for her. At the first court appearance, ACS requested the client to submit to random drug tests, engage in drug treatment, undergo a mental health evaluation, and accept preventive services in her home. ACS never alleged that the children were actually harmed or placed at risk of harm because of the client's marijuana use.

- ACS alleged another client had marijuana accessible on a kitchen table, on one occasion had a guest in the home who used marijuana, and reported she had used marijuana. At the first court date, ACS stated they had no concerns for the health or safety of the children, yet still charged the mother with neglect and asked her to take a drug test, undergo a CASAC evaluation, and submit to a mental health evaluation.

- According to ACS, another client neglected his children because he smoked marijuana and was not in a drug treatment program. ACS never alleged, nor was there any proof, that the client's use of marijuana harmed his children in any way. While ACS requested a release of the children to him, they also requested, and the family court granted, that he take random drug tests, undergo a CASAC evaluation, and accept homemaking services in the home. ACS also withheld a favorable resolution for the client when he did not want to testify against the mother of his children about her marijuana use.

- Finally, a fourth client was accused of neglecting her children because she reportedly smoked marijuana about 10 times per month and was not engaged in a drug treatment program. While ACS requested a release of the children to her, ACS conditioned the release upon the client participating in a daily drug treatment program, ultimately causing her to lose two part-time jobs and jeopardizing the family's housing.

- Some of our clients have been required to engage in services related to marijuana use, even when ACS has not filed a petition against them and they are not a respondent in the case. One client was not a respondent on the case involving his children. The court ruled against releasing the children to their mother and before the court would release the

children to their father, our client, ACS requested and the court required that he pass a drug test because he had a conviction for marijuana possession several years prior.

- Another client had a long-term partner who lived with her and who also used marijuana. ACS never filed a petition against our client's partner, but did ask the family court to force the partner to leave the home. The family court instead ordered that the partner could never be alone unsupervised with the children unless he engaged in a drug treatment program.

B. ACS Should Adopt A Policy That It Does Not Reject Family Resources for Children Because of Marijuana Use Past or Present.

In cases where the family court removes our client's children for other allegations, ACS has often rejected our client's family members because of marijuana use by the relative. This in turn has led to longer stays in foster care, placement with strangers and separation of siblings. This is why The Bronx Defenders recommends that Resolution 0740 be expanded to urge ACS to adopt a policy whereby it does not reject family resources for children based on marijuana use or past convictions for marijuana and is required to inform a parent and counsel of the barriers to placement of a child with that relative.

- For example, one client put forward her mother as a resource for her five oldest children. ACS opposed the children's placement with the maternal grandmother because the case worker had observed marijuana, belonging to an adult son, in the family home. For four months, the five children were separated and living in three different foster homes, all of them strangers to the children.

- The mother of another client was also initially rejected for her alleged marijuana use. The boys stayed at the foster care agency reception center for two months before the family court allowed them to go with their grandmother, over ACS's objection. The court required the grandmother, among other things, to attend random drug tests and an evaluation with the CASAC should any of the tests be positive for marijuana.

- When a third client had a new baby, ACS opposed having the baby reside with two family members who had admitted to using marijuana and instead sought to keep the newborn in foster care with strangers. The court disagreed, however, and placed the baby with the family members.

- Another client put forward her sister as a resource for her two children when ACS removed them from her care. The client's sister shared that she had a criminal conviction from over ten years prior regarding marijuana possession, and the Court and ACS required her and her husband to take a drug test before considering placing the children with her.

- In another case, our client's children were placed in foster care with their paternal great-aunt, with her consent. During the pendency of the case, ACS removed the

children from the home because the great-aunt stated she used marijuana. Our client requested that the children be returned to the aunt, and the family court granted the request on the conditions that the aunt submit to drug tests. The Court issued a ruling that ACS could not remove the children for a positive marijuana test on its own. When our client wished to relinquish custody of her children to their great-aunt, however, ACS purposefully delayed the order being entered until the great aunt tested negative for marijuana.

C. ACS Should Adopt a Policy That It Does Not Separate Families or Fail to Expand Family Contact Because of Marijuana Use

Of all the ways ACS and the courts punish families where a parent uses marijuana, the most consequential are those situations where they separate the family or delay reunification because of marijuana use. In many instances, marijuana use is the sole basis for the separation. This leads to further trauma for the children, as they spend time out of their parents' care. This is why The Bronx Defenders supports Resolution 0740.

- For example, ACS alleged that one client was accused of selling marijuana and having it accessible to her children in the home. She was issued just a desk appearance ticket to appear in criminal court, but ACS conducted an emergency removal and separated the children from their mother. The client and her partner asked for a hearing to return the children, which the family court granted, on condition that the client leave her permanent housing, enter a shelter, submit to random testing and undergo an evaluation by a CASAC.

- In another instance, ACS would not agree to our client returning to the family home with his children and their mother because he continued to use marijuana and was not engaged in a drug treatment program. He remained out of the home for months until he began testing negative for marijuana.

- Similarly, in another case, ACS would not agree to expand visitation between our client and his children from agency supervised visits to visits supervised by a relative because he continued to use marijuana, and was not engaged in a drug treatment program. Despite the fact that the agency supervised visitation between our client and his children had gone well, ACS denied the expansion to more meaningful parent-child contact because of marijuana use.

- ACS removed another client's children from him and filed a petition alleging marijuana use, marijuana being accessible in the home, and having a dirty home. Our client requested a hearing for the return of his children to his care. During the six weeks while the hearing was pending, our client engaged in a drug treatment program, as ACS had requested, to address his marijuana use. However, the insurance co-pays were financially prohibitive, leading our client to request that ACS make those payments. Despite their position that our could not be reunited with his children without a drug treatment

program, ACS refused to pay. The family court ordered ACS to pay, and ACS settled the hearing six weeks after they removed the children from their parents.

- ACS filed a case against another client with allegations unrelated to marijuana use. Over time, our client engaged in services and was making progress toward the return of her children. After our client said that she used marijuana, both ACS and the court refused to allow our client to have any overnight visits with her children until she tested negative for marijuana.

- For one 16-year-old client, the court and ACS denied her the opportunity to visit with her baby at her mother's home because of her alleged marijuana use. The maternal grandmother was a certified foster parent and our client's baby was placed in her care. This denial led our client to lose bonding time with her baby, as she was only allowed visitation at the foster care agency.

Recommendations

- The Bronx Defenders supports Initiative 1426 as it calls upon ACS to report on investigations initiated by health facilities and include information about the subjects of the reports. We suggest that it be expanded to all health facilities rather than just those facilities managed by the New York City Health and Hospitals Corporation. We also recommend that it be amended to require ACS to report on the race of each patient and whether the infant was separated from his or her mother by the hospital or by ACS as a result of a positive drug test.
- The Bronx Defenders supports Initiative 1161 as it requires ACS to enhance its reporting and report on the main allegations that led to the receipt of a report and so that there is greater transparency around when marijuana use is the basis for an investigation.
- The Bronx Defenders supports Resolution 0740 as it calls upon ACS to implement a policy that a person's mere possession or use of marijuana does not by itself result in family separation. We recommend that the resolution be expanded to also require ACS to adopt a policy that mere possession of marijuana without indicia that a child is neglected does not by itself result in the filing of a neglect petition for court ordered supervision or result in the rejection of family resources for children who must otherwise enter foster care.
- The Bronx Defenders supports Resolution 0746 as it calls on New York State to pass legislation requiring the New York Department of Health to create clear and fair regulations for the drug testing of pregnant women and for pregnant women to be informed of their rights prior to testing. Specifically, we recommend that the City Council support the enactment of Assembly bill 5478, with the amendment that it specifically apply to postpartum women and their newborns and require notice of the legal consequences of a positive test and clear informed consent from a pregnant or postpartum woman prior to drug testing her or her infant.

- The Bronx Defenders supports Resolution 0075 as it calls on New York State to pass the Marijuana Regulation and Taxation Act (MRTA) which includes a number of proposed changes to the law addressing marijuana use by parents.
- The Bronx Defenders recommends that the City Council pass a resolution calling on New York State to adopt a law that would require the Office of Family Services to review the list of people on the SCR with indicated cases, determine which of those people have indicated cases based solely on marijuana use, and amend and seal their cases.
- We recommend that the City Council pass a resolution calling on New York State to pass legislation reforming the SCR to remove unfair barrier to employment for parents, shortens the time a parent remains on the SCR for certain allegations, and make it easier to amend and seal one's case on the SCR. so that it does not harshly penalize parents and needlessly interfere with their ability to economically support their children. reform the SCR.

NDS
HARLEM

TESTIMONY OF THE NEIGHBORHOOD DEFENDER SERVICE OF HARLEM

before the

New York City Council

IN RELATION TO

Impact of Marijuana Policies on Child Welfare

by

MICHELLE BURRELL
MANAGING ATTORNEY
FAMILY DEFENSE PRACTICE

March 4, 2019

Testimony of Michelle Burrell

Introduction

I am Michelle Burrell, the Managing Attorney of the Family Defense Practice at the Neighborhood Defender Service of Harlem (NDS). NDS is a community-based defender office that provides high-quality legal services to residents of Northern Manhattan and a social justice leader. In 1990, NDS created a new model for a community-based, collaborative, client-centered approach to representing clients that has led to improvement of defense services throughout New York State and the rest of the country. Since 1990, NDS has grown from a pilot project of the Vera Institute of Justice into an independent, full-service legal and social service provider. We remain committed to a broad approach that addresses the social justice issues affecting our clients, their families and their communities. In 2018, NDS awarded with the "Defender of Justice Award" from the National Association for Public Defense, recognizing NDS as the Public Defender Office that best exemplified nationally NAPD's mission to advocate for those who cannot afford a lawyer.

In 2014, NDS re-introduced the Family Defense Practice. The Family Defense Practice exclusively represents parents from Northern Manhattan in abuse and neglect proceedings in Family Court. NDS' community-based, collaborative, client-centered model has served our clients well in Family Court. NDS should serve as a model office as New York State seeks to improve parental representation across the State. To date, NDS' Family Defense Practice has represented over 1600 parents from Northern Manhattan.

Law on Misuse

Under Family Court Act section 1046(a)(iii), proof that a parent repeatedly uses marijuana is sufficient evidence to consider their child a "neglected child," even when ACS presents no evidence whatsoever that the child was harmed or at risk of harm based on the parent's marijuana use.

This law includes two presumptions that should be reconsidered. First, the law, and ACS and courts applying this law presume that marijuana is a drug that "ordinarily ha[s] the effect of producing [its] ... users ... [in] a substantial state of stupor, unconsciousness, intoxication, hallucination, disorientation, or incompetence, or a substantial impairment of judgment, or a substantial manifestation of irrationality." As a result, the law further presumes that a parent who repeatedly uses marijuana places their children at risk, regardless of the circumstances of their use or whether the children were or could have been affected by their marijuana use.

Although amendment of the Family Court Act by the state legislature would be required to rectify these outdated and scientifically unsupported presumptions, both this Council and ACS

can and should take a different approach. Resolution 740 can begin the process of unraveling the biased and devastating impacts of the overly aggressive child welfare prosecution of parents for marijuana use.

ACS Removes Children and Files Neglect Cases Based on Marijuana Use by Parents

On November 27, 2018, during a hearing before the City Council, Council Member Stephen Levin asked ACS Commissioner Hansell "are there ever any instances where... marijuana use by a parent is a determining factor for either removal or court ordered supervision or an indication of a neglect case?" Commissioner Hansell responded: "No. Marijuana use per se would never be the basis for an indicated finding of abuse or neglect, it would only be marijuana use, or for that matter any substance abuse that has an impact on parenting capacity or ability to provide adequate guardianship for a child." While we have heard ACS leadership proclaim that mere marijuana use is not a basis that is used to separate families, that assertion does not reflect the daily reality for our clients and the community.

Unfortunately, the Commissioner's testimony does not reflect the daily reality for our clients and, particularly, communities of color. The clients we represent and the communities which they come from face a much different reality. We have numerous clients who are currently separated from their children based specifically on allegations of marijuana use.

Ms. Smith's five-year-old son Jason was removed from her care in 2016 based on an allegation that Ms. Smith used marijuana on one occasion and was not enrolled in a substance abuse treatment program.[1] Due to the fact that Ms. Smith works two jobs, she has been unable to engage in a substance abuse treatment program. Nevertheless, Ms. Smith stopped using marijuana and has been testing negative for marijuana since March 2018. ACS acknowledges that Ms. Smith and her son Jason have a healthy, strong and loving bond. However, ACS is not only opposing Jason returning home with his mother, but they are also opposed to expanding visitation beyond agency supervised visits. ACS's rationale for supporting this position is that Ms. Smith has not yet completed a substance abuse treatment program. What is even more disconcerting is the fact that ACS has changed the permanency goal from Return to Parent to Adoption and is now threatening to file a Termination of Parental Rights proceeding.

As I submit this testimony today, one of our attorneys is on trial defending Mr. James. When Mr. James' son, Junior, was born, ACS removed his son from his care and commenced a neglect proceeding against him based on his marijuana use. Mr. James and Junior remain separated despite the fact that prior to his son's birth, Mr. James made time in his busy work schedule to engage in a substance abuse treatment program and a young father's program to prepare for his first child's arrival. Mr. James completed the young father's program, continues in his drug treatment program and is testing negative. However, ACS will not return Mr. James' son to his care because he has not completed the substance abuse treatment program.

[1] All client and their children's names have been changed for confidentiality reasons.

In another case, Ms. Green tested positive for marijuana at the birth of her child. With no other children and no prior history, ACS filed a petition against her based solely on the positive marijuana toxicology.

Similarly, Ms. Woods tested positive for marijuana at the birth of her child. Rather than coming to court, ACS agreed not to file a petition on the contingency that Ms. Woods enroll in drug treatment. Because of housing instability, months later Ms. Woods had not participated consistently in drug treatment and ACS came to court asking that the child be removed from Ms. Woods and placed solely in the custody of the father of the child, who she lived with. Such an order had the potential to render Ms. Woods homeless. Thankfully, she was allowed to stay in the home with the father after the advocacy of both our attorney and the attorney for the child.

This is why Resolution 740 is extremely important. It will provide the family defense attorneys and advocates, with clear statutory and legal support to defend parents like Ms. Smith and Mr. James, and to ensure that families are not unjustly and needlessly separated. Resolution 740 will also bring us one step closer to addressing the disproportionate amount of Black and Brown children who are the subject of child protective proceedings and who are removed from their parents.

According to OCFS's own data, in New York City, three-fourths of children in foster care are Black or Latino, while another 18 percent are classified as of unknown race or ethnicity.[2] Only six percent are White. In other words, it appears that potentially 94% of all children in foster care in New York City are children of color.

It must be said that in the same way the criminal legal system has been known to separate Black and Brown men from their families, the child welfare system is the cause for the separation of Black and Brown women from their families. The renowned Professor Harry Levine, who has performed some of the most extensive research on race, policing and marijuana use in New York City – found that while Blacks and Latinos use marijuana at lower rates than Whites, 87% of marijuana possession arrests have been of Blacks and Latinos.[3]

Just as communities of color have been unfairly targeted by the police for marijuana use, they have also been unfairly targeted by ACS. For parents like Ms. Smith and Mr. James and their children, passing Resolution 740 will be a significant step in preventing the unnecessary separation and prosecution of families, and also provide them with clear statutory and legal support to assist in their defense.

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[2] New York State Office of Children and Family Services, Office of Strategic Planning and Policy Development, Bureau of Research, Evaluation and Performance Analytics, *2017 Monitoring and Analysis Profiles With Selected Trend Data: 2013-2017,* https://ocfs.ny.gov/main/reports/maps/counties/New%20York%20City.pdf

[3] Harry G. Levine and Loren Siegel, *Marijuana Madness, The Scandal of New York City's Racist Marijuana Possession Arrests.* (2015) (Marijuana Use data is from U.S. Dept HHS, SAMHSA, Office of Applied Studies)

Public Hospitals' Drug Testing Without Consent Contributes to ACS Prosecution of Parental Marijuana Use Investigations and Neglect Cases

ACS's prosecution of marijuana cases is aided and abetted by public hospitals who routinely drug test our clients—who are predominately black and brown women from poor communities in Harlem—with or without their informed consent. We know that this is happening because the petitions filed in court tell us that our clients tested positive for marijuana at the time of their child's birth. The petitions tell us that the hospitals where our clients give birth are public hospitals—most frequently those run by New York Health and Hospitals Corporation. The petitions tell us that our clients were subjected to intrusions on their bodily integrity in a way that wealthier, whiter communities are not.

What the petitions do not tell us is whether our clients ever consented to these intrusions. Whether they were ever informed of their right to refuse such testing, both for themselves and for their newborn child. Whether they were ever even informed that the testing was done until they were visited in their hospital room by an ACS worker. We do know, however, that at least in some cases these tests are being affirmatively refused and our clients' babies are being tested anyway.

In one case, evidence that this is happening can be found in medical records that an attorney in my office received from ACS as part of discovery on a marijuana case. Reading through the records, the attorney discovered that our client was informed by hospital staff that even if she didn't consent to having a drug test performed on herself, the hospital would test her newborn baby anyway. The hospital was asking this of her because she didn't "react well" to labor and didn't have "a lot of support." The hospital justified this threat under the guise of ensuring the safety of the child. Did they stop to think about whether they would make this same request of a wealthier or white mother?

In a recent Rolling Stone article, it was noted that New York Health and Hospitals Corporation released a corporate policy in 2014 that outlined "risk indicators" to consider when deciding whether to perform alcohol and drug screenings on mothers and newborns. Risk indicators included minimal or no prenatal care, a history of substance abuse or treatment within the previous three months, placental abruption and severe mood swings.[4] As noted by a spokesperson for the Association of Obstetrics and Gynecology in that same article, "a list like this would perpetuate stigma and selective screening is not recommended in most contexts."[5] For our client the stigma was acutely felt when the hospital ultimately did test her newborn child without her consent—which led directly to an ACS case based upon allegations of pre-birth marijuana use.

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[4] Haley Fox, *Weed and Pregnancy: How Cannabis Laws Are Hurting Mothers*, Rolling Stone (November 17, 2018, 8:30 AM), https://www.rollingstone.com/culture/culture-features/weed-pregnancy-mother-family-marijuana-cannabis-755697/

[5] *Id.*

Unfortunately, this fact pattern is all too common for those of us on the front lines. Sitting in family court and observing the faces that pass through the revolving door of the child welfare matrix makes one painfully aware of just how overrepresented parents of color are in this system. If what we see is indicative of reality, then the only parents who use marijuana during pregnancy are poor mothers of color. But we know that this isn't true, particularly when some recent national studies indicate that 30% (or approximately 16,353,060) of adults that use marijuana are parents of children under the age of 18.[6] The courtrooms of family court certainly don't reflect that reality.

Parental Marijuana Use is Routinely Considered an Impediment to Progress in Child Welfare Cases

While Resolution 740 rightly speaks to the wrongful presumption by ACS that mere possession or use of marijuana can by itself create an imminent risk of harm to a child, warranting the child's removal, there are numerous additional collateral consequences of marijuana use in child welfare proceedings both more and less severe than removal.

The most common consequence that our clients face is the refusal to expand parenting time beyond supervised visits that take place at the agency. This is important because the expansion of visitation generally leads to reunification. The less restrictive the visitation plan, the more trust that judges have for parents having full and unfettered access to their children. However, even when the allegations that led to the removal are not related to marijuana use, a positive drug test for marijuana is routinely used as a barrier to expansion of visitation (regardless of the fact that the use was not done around the child) and/or it can be used to restrict a more liberal visitation plan. Especially because marijuana can stay in the bloodstream for at least 30 days, testing for marijuana does not indicate how much use occurred.

Likewise, where a parent has a child home from foster care on a trial basis, known as a "trial discharge", marijuana use will be cited by ACS and approved by courts as a reason not to move forward with a "final discharge" that would end the court and ACS's involvement and supervision over the family, even where there are no other safety concerns and no evidence that the parent's marijuana use specifically poses a risk of harm to the child.

Terminations of parental rights, the civil death penalty, have been ordered, and upheld, by New York City Family Courts based on a parent's continued marijuana use while their child is in foster care. This means that due to a parents use of marijuana, they lose any right to see their

[6] Yahoo News/Marist Poll: Weed & The American Family, released April 17, 2017, http://maristpoll.marist.edu/wp-content/misc/Yahoo%20News/20170417_Summary%20Yahoo%20News-Marist%20Poll_Weed%20and%20The%20American%20Family.pdf

child, visit with them, learn about them, or have any contact at all, and they become a total legal stranger to their child, who may be adopted without their consent.

Additionally, we know that hundreds of New Yorkers have indicated cases in the State Central Registry, cases that never result in court intervention. We do not know how many of those indicated cases are based on marijuana use. This is important because an indicated case can stay in the State Central Registry until the youngest child on the report turns 28. This can result in lost employment prospects in the field of childcare.

Therefore, there are many collateral consequences that may result from a positive marijuana test, for a parent, that don't only include the removal of a child.

Recommendations

1. Require ACS to report annually on the frequency of marijuana allegations at all points in the proceeding.
    a. In order to ensure that ACS accurately and consistently reports on their treatment of how marijuana use effects their decision-making, it is important that they be required to report on how they use marijuana in their decision-making at all stages in a neglect proceeding.
    b. New York City can and should require ACS to collect and report on:
        i. When marijuana is the only factor that leads to the filing of a neglect petition
        ii. When marijuana use is the only impediment to expansion of visits
        iii. When marijuana use is the impetus for reducing the prior expansion of visits
        iv. When marijuana use is the basis for the failure of a trial discharge
        v. When marijuana use is the basis for the filing of Termination of Parental Rights
        vi. When marijuana use is the basis for an indicated case in the State Central Registry
2. Implement a policy, in coordination with ACS, that accurately assesses the risk of harm of marijuana use while parenting in accordance to the current science.
    a. The assumption that any marijuana use is misuse and that use alone would create imminent risk to a child, is a prevailing myth that needs to be challenged. While we cannot dictate how judges perceive the use of marijuana, ACS and this Council can create a policy drastically limiting the use of marijuana as a reason to remove a child.

Rise

Testimony Before the New York City Council Committee on General Welfare
Stephen Levin, Chairperson
Jointly with the Committee on Hospitals
Carlina Rivera, Chairperson

April 10, 2019

Hello, I'm Robbyne Wiley, a Parent Leader at Rise. Rise supports parents to become advocates for change in child welfare. I am a parent who was affected by the child welfare system. From being on that side of the table, I can now support other parents, and train professionals working in the system to understand parents' perspectives.

I'm here today to support changes to the law and policies that will reduce the fear and injustice that exists in my community because of the threat of ACS investigation and family separation.

I am familiar with the fear that can prevent a parent from seeking help. When the crack epidemic was going on, many children were being removed from the arms of their parents, especially in Harlem and the South Bronx. This made me very fearful to ask for the help I so desperately needed.

Two of my three children were removed from my care a year before I realized I was pregnant with my fourth child. I feared going to get prenatal care, constantly thinking that if I did my baby would be removed at birth. That fear prevented me from getting the medical care and treatment I should have gotten during my pregnancy.

Then, the day after my baby was born with positive toxicology, he was removed. I was tested without my knowledge or my consent and the response was to discharge me alone without my son, and without any help.

If I had just had an open and honest doctor to ask if there was something going on that I wanted to talk about, I might have felt comfortable and been able to get help. Someone could have offered me services, not just fear. Research now says it's important to do everything possible to help parents keep the bond with a newborn child. That means programs where parents and children can go through the journey of rehab together, and policies that tell parents, "As long as you keep doing what is best for you and your child, you don't have to be concerned about your child being removed." That wasn't the message I got. I felt trapped and alone.

Today, fewer children are removed from their parents than they were when my children were in the system, but more parents than ever before are being investigated. The fear that parents feel when getting that knock on the door cannot be overstated. Parents in my community today are still living with the fear that they will lose their children based on drug use. That causes parents who need help not to get it. Some parents don't need help, because their use of marijuana is not a safety threat to their children. These parents still feel threatened and unsafe.

As one parent wrote for Rise, "When we are investigated, we don't expect it to be fair. So when we hit a crisis, our fear keeps us hiding under a rock."

To feel safe, parents need clear information about the law. ACS should report on how often hospitals are making reports against parents, and hospitals should have clear policies about when they drug test pregnant women and how they inform patients of their rights. Hospitals should not drug test patients without their knowledge and consent and should not report drug use as child neglect without evidence of harm. Hospital policies should include how they offer help, not just judgment. In order for parents to have a different perspective on how to deal with the issues in their lives they need assurance that help is available in their communities and hospitals without fear of having their children removed.

As we move forward to legalization of marijuana, parents need to understand how this may or may not affect them. ACS should make clear that children will not be removed because of parents' marijuana use when there's no clear harm.

It's so important to reduce fear, and that can only happen if we stop unnecessary investigations and removals.

National Advocates for Pregnant Women
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National Advocates for Pregnant Women

Testimony Before the New York City Council Committee on General Welfare
Stephen Levin, Chairperson
Jointly with the Committee on Hospitals, Carlina Rivera, Chairperson

In Support of: Int. 1161-2018, Int. 1426-2019, Res. 0740-2019, Res. 0746-2019

April 10, 2019

National Advocates for Pregnant Women is pleased to provide written testimony alongside fellow activists, allies, and New York City Council Members in their support of these administrative code amendments and resolutions to address the impact of "Marijuana Policies on Child Welfare."

National Advocates for Pregnant Women is a non-profit organization founded in 2001 that uses legal advocacy, public education, and organizing to secure the civil and human rights of all pregnant people, including those most likely to be targeted for state control – low-income women, women of color and women who use drugs. We seek to ensure that no person is prosecuted, civilly or criminally, for being pregnant, or for any outcome of their pregnancy, whether one has an abortion, experiences a pregnancy loss, or delivers a baby.

NAPW is pleased to support the proposed New York City administrative code amendments to enhance reporting about the child welfare system by the Administration for Children's Services (ACS), including the number of investigations triggered by drug screenings conducted at certain New York hospitals, as well as the proposed resolutions calling upon the New York State legislature to pass a law that protects the rights of pregnant patients, and ACS to pass a policy that protects the right of families to remain together.

These initiatives are necessary to learn more about the treatment of parents brought into the child welfare system because of alleged marijuana use, as well as to ensure that any concerns regarding substance use and pregnancy are not used to excuse violations of pregnant women's rights or children's rights to be with their families. Like many of those who work to advance maternal, fetal, and child health, NAPW recognizes that confidential, voluntary, and respectful treatment, rather than force, coercion, or punishment, are the most effective ways of supporting positive pregnancy outcomes for all pregnant women including those who use drugs and those with actual substance use disorders. However, any policy or procedure that incorrectly conflates substance use with child abuse undermines families, as it deters women from accessing needed healthcare; is not supported by science; and violates the fundamental rights of mothers and their children.

Protecting pregnant patients' rights advances the public health.

Research has found that pregnant women of color and those seeking medical care through publicly funded health facilities are more likely to be drug tested or have their newborn babies tested, usually without their direct knowledge or explicit consent.[1] Healthcare providers may-in-turn report positive toxicology results to departments of social services as reports of suspected child abuse or neglect. There is also evidence that involvement with or fear of government interventions may deter pregnant women from obtaining care and consultation with doctors out

[1] Khiara Bridges, The Poverty of Privacy Rights Introduction & 110-122 (Stanford University Press 2017); *see also* MA Armstrong et al., *Does adopting a prenatal substance use protocol reduce racial disparities in CPS reporting related to maternal drug use? A California Case Study,* 35 Journal of Perinatology 146 (2015).

of fear of being reported to government officials, including the child welfare system.[2]

These issues have been addressed by medical groups, including the American College of Obstetricians and Gynecologists, who have explained that: "[s]eeking 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."[3] We have attached as an exhibit to this testimony collected statements from leading public health and human rights organizations opposing punitive approaches to pregnant women and substance use.[4] It should also be noted that there is no requirement in the federal Child Abuse Prevention and Treatment Act or its amendments that require drug testing of pregnant women or their newborn children.[5]

NAPW supports Resolution 0746 as it calls on New York state to pass legislation requiring the New York Department of Health to create clear and fair regulations on drug testing pregnant patients, and for patients to be informed of their rights *prior* to any test being conducted. The Resolution is consistent with the American Medical Association's (AMA) position that a relationship of trust is critical for effective medical care as a "patient should feel free to make a full disclosure of information to the physician" which allows the physician to "effectively provide needed services."[6]

If the state legislation is passed, we implore the Department of Health to carefully consider regulations that only request patients to be drug tested if a specific medical need has been identified and the patient's explicit consent has been received. As an article on marijuana use, the child welfare system, and drug testing explained:

> At a national level, organizations like The American College of Obstetricians and Gynecologists attempt to guide responsible medical behavior by issuing guidelines for urine drug testing that dictate the practice should not be used as a coercive measure or a form of punishment. The test is also not intended as yardstick for measuring new moms;

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[2]Nancy Poole & Barbara Isaac, *Apprehensions – Barriers to Treatment for Substance-Using Mothers* 12 (British Columbia Centre of Excellence for Women's Health 2001) (62% of the study's participants identified fear of losing their children as a barrier to treatment); Sarah Roberts & Cheri Pies, *Complex Calculations: How Drug Use During Pregnancy Becomes a Barrier to Prenatal Care,* 15 Maternal and Child Health J. 333, 338 (2011) (study showed that "most women feared that attending prenatal care while using drugs would lead to CPS reports and losing their children"); Seema Mohapatra, *Unshackling Addiction: A Public Health Approach to Drug Use During Pregnancy,* 26 Wis. J.L. Gender & Soc'y 241, 245 (2011). *See also* Martha Jessup et al., *Extrinsic Barriers to Substance Abuse Treatment Among Pregnant Drug Dependent Women*, 33 J. Drug Issues 285, 299 (2003) (Studies have found that fetal health can only "be legitimately pursued and achieved through maternal protection, in the form that nonpunitive therapeutic interventions afford. Results from this study confirm that mothers themselves also have the child's welfare as their priority concern.")

[3] American College of Obstetricians and Gynecologists, Committee Opinion Number 473 of the College's Committee on Health Care for Underserved Women (January 2011).

[4] *See* NAPW, Collection of Medical, Public Health and Human Rights Group Statements (attached hereto as Exhibit A).

[5] *See generally* 42 U.S.C. § 5106a; NAPW, Understanding CAPTA and State Obligations (2018) (attached hereto as Exhibit B), http://advocatesforpregnantwomen.org/CAPTA%20requirements%20for%20states_NAPW.pdf.

[6] *The AMA Code of Medical Ethics' Opinions on Confidentiality of Patient Information,* 14 American Medical Association Journal of Ethics 715 (2012).

> "there's nothing in a urine drug test that tells you anything about behavior," says ACOG's [Dr.] Terplan. "It's not a motherhood test."[7]

Such a regulation would not only be consistent with medical recommendations but would undoubtedly save the state significant amounts of money otherwise being spent on costly and medically unnecessary drug testing.[8]

Connecting any amount of substance use & pregnancy to child neglect/abuse is wrong.

Every state across the country has civil statutes addressing civil child neglect, yet there is no research that establishes a causal link between a person who has used some amount of controlled substances to the likelihood to abuse a child.[9] Further, medical facts show that *the assumption is simply incorrect that a baby born with a positive toxicology for a variety of substances means the baby is harmed*. Specifically, when addressing pregnancy and marijuana use, experts have found that it is *not* related to potentially adverse birth outcomes, including low birth weight, preterm delivery, or neonatal intensive care unit (NICU) admissions.[10] Further, "human data have not identified any long-term or long lasting meaningful differences between children exposed in utero to cannabis and those not."[11]

On the other hand, experts have noted the potentially adverse impacts of unnecessary child welfare interventions. As one expert noted, "even in environments where cannabis is legal, pregnant women may end up involved with Child Protective Services. In states where substance use is considered child abuse this may be especially catastrophic. Above all, care for pregnant women who use cannabis should be non-punitive and grounded in respect for patient autonomy."[12]

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[7] Haley Fox, *Weed and Pregnancy: How Cannabis Laws are Hurting Mothers,* Rolling Stone (Nov. 17, 2018), https://www.rollingstone.com/culture/culture-features/weed-pregnancy-mother-family-marijuana-cannabis-755697/.
[8] Schulte et al., *Liquid Cold: Pain Doctors Soak Up Profits by Screening Urine for Drugs,* Kaiser Health News (Nov. 6, 2017), https://khn.org/news/liquid-gold-pain-doctors-soak-up-profits-by-screening-urine-for-drugs/.
[9] "As research has repeatedly shown, a woman who uses drugs while pregnant or while parenting is not ipso facto an incompetent mother." Ian Vandewalker, *Taking the baby before its born: Termination of the parental rights of women who use illegal drugs while pregnant,* 32 N.Y.U. Rev. L. & Soc. Change 423, 439 (2008) *citing* Susan C. Boyd, *Mothers and Illicit Drugs: Transcending the Myths* 14-16 (1999) (reviewing fourteen studies demonstrating that women who use illegal drugs can be fit parents). *See also* Kathryn Dee L. MacMilla et al., *Association of Rooming-in With Outcomes for Neonatal Abstinence Syndrome: A Systematic Review and Meta-analysis*, JAMA Pediatrics (2018) (Viewing women who use any amount of drugs as a danger to their children has led to terrible, costly, and medically unjustified interventions that separate women and newborns); Brenda Smith, *The risk of subsequent maltreatment allegations in families with substance-exposed infants* 26 Child Abuse & Neglect 97 (20014); Christina White, *Federally Mandated Destruction of the Black Family: The Adoption and Safe Families Act*, 1 Nw. J. L. & Soc. Pol'y 303, 321 (2006).
[10] Terplan et al., *Marijuana use and pregnancy: prevalence, associated characteristics, and birth outcomes*, 19 Arch. Women's Ment. Health 105 (2016).
[11] Terplan, *Cannabis and pregnancy: Maternal child health implications during a period of drug policy liberations*, 104 Preventative Medicine 46, Abstract (2017).
[12] *Id.*

Family separation is harmful to children's health

Resolution 740 supports what experts have long agreed upon, it is in the best interest of children to remain in the care of their parents. "All the evidence shows that children thrive most in permanent families, and that severance of the family bond and placement in foster care, in and of itself, causes trauma to children . . . Breaking the primary attachment bond is harmful to children and should only be done as a last resort, when it is clear a parent cannot become fit."[13] This remains true for children who may have been prenatally exposed to a controlled substance.

> "For example, one study at the University of Florida compared cocaine-exposed babies who were put in foster care with those who were left with their birth mothers. The infants who stayed with their natural mothers showed better neurological and physical development than those in foster care. As one commentator put it, separation from their mothers was more toxic than the cocaine to the foster care children."[14]

Family separation, and the trauma it causes, should only be considered as a last resort when absolutely necessary to ensure the safety of children, not as a result of faulty assumptions and prejudices growing out of decades of problematic and often counter-productive drug policies.[15]

We hope this information will be useful as you decide whether to support these resolutions and amendments.

Thank you,

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National Advocates for Pregnant Women

[13] Valerie L'Herrou, *Aging Out: 2018 Legislation Seeking to Address Virginia's Permanency Problem for Children in Foster Care*, 22 Rich. Pub. Int. L. Rev. 49, 57-59 (2019); *see also* Joseph J. Doyle, Jr., *Child Protection and Child Outcomes: Measuring the Effects of Foster Care*, 97 Am. Econ. Rev. 1583, 1584 (2007); Douglas F. Goldsmith et al., *Separation and Reunification: Using Attachment Theory and Research to Inform Decisions Affecting the Placements of Children in Foster Care,* 55 JUV. & FAM. CT. J. 1, 11 (2004); Anu-Katriina Pesonen et al., *Childhood Separation Experience Predicts HPA Axis Hormonal Responses in Late Adulthood: A Natural Experiment of World War II*, 35 Psycho neuroendocrinology 758, 762-63 (2010) (explaining that children separated from their parents during WWII experienced higher levels of stress hormones through adulthood).
[14] Ian Vandewalker, *Taking the baby before its born: Termination of the parental rights of women who use illegal drugs while pregnant,* 32 N.Y.U. Rev. L. & Soc. Change 423, 439 (2008).
[15] *Nicholson v. Scoppetta,* 3 N.Y.3d 357, 374-375 (NY 2004) ("New York has long embraced a policy of keeping biological families together. Yet when a child's best interests are endangered, such objectives must yield to the State's paramount concern for the health and safety of the child") (internal citations and quotations omitted).

National Advocates for Pregnant Women
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Exhibit A

Medical, Public Health & Human Rights Group Statements Opposing Punitive Intervention for Pregnant Women

American Academy of Pediatrics

"Qualitative research performed in pregnant women with substance use disorders shows that women may avoid prenatal care for fear of being reported to the police and child protective services…the AAP supports an approach toward substance use in pregnancy that focuses on a public health approach of primary prevention, improving access to treatment, and promoting the provider-patient relationship rather than punitive measures through the criminal justice system." American Academy of Pediatrics, Committee on Substance Use and Prevention, Policy Statement, *A Public Health Response to Opioid Use in Pregnancy* (2017).

American College of Obstetricians and Gynecologists

"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." 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).

"…[I]t is important to advocate for this often-marginalized group of patients (patients with substance use disorders) particularly in terms of working to improve availability of treatment and to ensure that pregnant women with opioid use disorder who seek prenatal care are not criminalized. Finally, obstetric care providers have an ethical responsibility to their pregnant and parenting patients with substance use disorder to discourage the separation of parents from their children solely based on substance use disorder, either suspected or confirmed. In states that mandate reporting, policy makers, legislators, and physicians should work together to retract punitive legislation and identify and implement evidence-based strategies outside the legal system to address the needs of women with addictions." American College of Obstetricians and Gynecologists Committee on Obstetric Practice, Committee Opinion 711, *Opioid Use and Opioid Use Disorder in Pregnancy* (2017).

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American Medical Association

"Transplacental drug transfer should not be subject to criminal sanctions or civil liability . . . In particular, support is crucial for establishing and making broadly available specialized treatment programs for drug-addicted pregnant and breastfeeding women wherever possible. . ." American Medical Association, Policy Statement - H-420.962, *Perinatal Addiction - Issues in Care and Prevention* (last modified 2017).

American Society of Addiction Medicine

"In order to prevent harm to mothers and infants, ASAM recommends the following: …Substance use disorder treatment services able to meet the specific needs of women, including pregnant and parenting women, and their families: …Preservation of the physician-patient relationship, so that laws or regulations should not require physicians to violate confidentiality by reporting their pregnant patients with current or past history of substance use to legal authorities and/or child welfare services in the absence of evidence of child abuse or neglect." American Society of Addiction Medicine, *Public Policy Statement on Women, Alcohol and Other Drugs, and Pregnancy* (2011).

"It is inappropriate to reflexively move from the possibility to an alleged certainty of defective parenting or danger to the child simply because of evidence of substance use . . . Sanctions against parents under child protective services interventions should be made only when there is objective evidence of danger, not simply evidence of substance use." American Society of Addiction Medicine, *Public Policy Statement on Substance Use, Misuse, and Use Disorders During and Following Pregnancy, with an Emphasis on Opioids* (2017).

"State and local governments should avoid any measures defining alcohol or other drug use during pregnancy as 'child abuse or maltreatment,' and should avoid prosecution, jail, or other punitive measures as a substitute for providing effective health care services for these women." American Society of Addiction Medicine, *Public Policy Statement on Substance Use, Misuse, and Use Disorders During and Following Pregnancy, with an Emphasis on Opioids* (2017).

National Perinatal Association

"Treating this personal and public health issue (perinatal substance use) as a criminal issue-or a deficiency in parenting that warrants child welfare intervention-results in pregnant and parenting people avoiding prenatal and obstetric care and putting the health of themselves and their infants at increased risk…The threats of discrimination, incarceration, loss of parental rights, and loss of personal autonomy are powerful deterrents to seeking appropriate prenatal care. Perinatal providers promote better practices when they adopt language, attitudes, and behaviors that reduce stigma and promote honest and open communication about perinatal substance use." National Perinatal Association, Position Statement, *Perinatal Substance Use* (2017).

"As clinicians, mental health, and community care providers, it is imperative that we understand the nature of perinatal substance use disorders and provide interventions and care that preserve the parent-infant dyad, promote parenting potential, and support the baby's health and development." National Perinatal Association, Position Statement, *Perinatal Substance Use* (2017).

National Association of Public Child Welfare Administrators

The National Association of Public Child Welfare Administrators has stated that "laws, regulations, or policies that respond to addiction in a primarily punitive nature, requiring human service workers and physicians to function as law enforcement agents are inappropriate." National Association of Public Child Welfare Administrators, *Guiding Principles for Working With Substance-Abusing Families and Drug-Exposed Children: The Child Welfare Response* (1991).

Amnesty International

"In the USA, pregnant women lie at the center of a contested battleground over their sexual and reproductive rights and for some, this intersects with a stigmatizing and punitive state response to drug use. However, neither the condition of pregnancy nor one's drug use justify the violation of individuals' human rights…punitive approaches deter women from seeking healthcare services, have a discriminatory impact on marginalized individuals and effectively criminalize pregnancy for certain classes of women, violating their human rights." Amnesty International, *Criminalizing Pregnancy: Policing Pregnant Women Who Use Drugs in the USA* (2017).

"States have an obligation to respect, protect and fulfill the full range of human rights for all people, including pregnant women. These obligations apply to both states' law and policy-making, criminal and civil law enforcement and provision of services, including health and social services." Amnesty International, *Criminalizing Pregnancy: Policing Pregnant Women Who Use Drugs in the USA* (2017).

"When pregnant women are threatened with criminal punishment when seeking healthcare services, when they are tested for drugs without their informed consent, when they lack access to drug treatment and when their healthcare providers share information with law enforcement to punish them, as opposed to providing essential care, then these actions constitute potential violations of their right to the highest attainable standard of health". Amnesty International, *Criminalizing Pregnancy: Policing Pregnant Women Who Use Drugs in the USA* (2017).

"Alarmingly, not only did the majority of the women interviewed for this report not give informed consent for drug testing in the context of maternity care, but many did not even know they were being tested. This violates pregnant women's right to health as well as their right to privacy." Amnesty International, *Criminalizing Pregnancy: Policing Pregnant Women Who Use Drugs in the USA* (2017).

"While states have a legitimate interest in promoting maternal health, efforts should be made to ensure that this aim actually underlies its laws, policies and practices around pregnancy and that they comply with human rights standards. As documented throughout this report, however, drug testing is a compulsory component of and effectively a condition to accessing prenatal healthcare for many women in the US. Additionally, those who had disclosed their drug use to a healthcare provider were more likely to be flagged for testing and those who had cases with CPS were often tested. These practices raise significant human rights concerns including potential violations of the right to health." Amnesty International, *Criminalizing Pregnancy: Policing Pregnant Women Who Use Drugs in the USA* (2017).

United Nations Special Rapporteur on Extreme Poverty and Human Rights

The U.S. "falls far short on" creating "policies designed to eliminate poverty" including the use of "confused and counter-productive drug policies" including "highly punitive regimes directed against pregnant women, rather than trying to provide sympathetic treatment and to maximize the well-being of the fetus." Professor Philip Alston, United Nations Special Rapporteur on Extreme Poverty and Human Rights, *Statement on Visit to the USA, by Professor Philip Alston, United Nations Special Rapporteur on extreme poverty and human rights** (2017).

" . . .[I]n the light of the Government's human rights obligations" there must be "policies designed to eliminate poverty" and promote "gender and racial equality." However, "the United States falls well short on . . .these measures." Instead, "[w] omen often experience the burdens of poverty in particularly harsh ways. Poor pregnant women who seek Medicaid prenatal care are subjected to interrogations of a highly sensitive and personal nature, effectively surrendering their privacy rights…When a child is born to a woman living in poverty, that woman is more likely to be investigated by the child welfare system and have her child taken away from her. Poverty is frequently treated as a form of 'child neglect' and thus as cause to remove a child from the home, a risk exacerbated by the fact that some states do not provide legal aid in child welfare proceedings." United Nations General Assembly, Human Rights Council, *Report of the Special Rapporteur on extreme poverty and human rights on his mission to the United States of America* (2018).

National Advocates for Pregnant Women
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Exhibit B

UNDERSTANDING CAPTA AND STATE OBLIGATIONS

September 2018

This fact sheet addresses common misconceptions about what states are required to do to comply with the federal Child Abuse Prevention and Treatment Act (CAPTA), with regard to newborn infants' prenatal drug exposure. Many states and local child welfare agencies have assumed that CAPTA – a federal funding provision – requires them to report all substance-exposed newborns to child welfare agencies as being abused or neglected. This assumption is incorrect; CAPTA does not require this.

When addressing the topic of child protection, it is particularly important to note that drug use is not the same as a substance use disorder (SUD) and that SUD is a medical condition – not a form of child neglect or abuse. Pregnant women do not experience drug dependencies because they don't care about their children. Like other medical and behavioral health conditions, substance use disorder is best addressed through treatment. Medical knowledge about dependency and treatment demonstrates that patients do not, and cannot, simply stop their drug use as a result of threats of legal charges or other negative consequences. In fact, threat-based approaches do not protect children. They do, however, frighten pregnant and parenting women away from seeking healthcare.[i]

What is CAPTA?

CAPTA is the key federal legislation addressing child abuse and neglect. Originally enacted in 1974, the law 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.[ii] One such requirement is that states enact laws mandating that certain professionals report known or suspected child abuse to a child protective services agency.[iii] In 2003, in response to alarmist and scientifically inaccurate information about pregnancy and cocaine use, Congress required that states arrange for "plans of safe care" for infants affected by "illegal" substance use, and in 2016, Congress enacted the Comprehensive Addiction and Recovery Act, including amendments to CAPTA requiring those "plans of safe care" be for infants affected by use of any substances, as well as for their parents. No funding was allocated for the added care presumed to be needed.

Does CAPTA Require States to Characterize Substance Use in Pregnancy as Child Abuse?

No. CAPTA specifically does not "establish a definition under Federal law of what constitutes child abuse or neglect; or (II) require prosecution for any . . . action."[iv]

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What Does CAPTA Require?

Under CAPTA, states must have: "policies and procedures (including appropriate referrals to child protection service systems and for other appropriate services) to address the needs of infants born with and identified as being *affected by substance abuse* or *withdrawal symptoms resulting from prenatal drug exposure*, or *a Fetal Alcohol Spectrum Disorder*, including a requirement that health care providers involved in the delivery or care of such infants notify the child protective services system of the occurrence of such condition in such infants."

Does CAPTA Require Testing All Newborns for Drug Exposure?

No. CAPTA does not require testing of all newborn babies.

Does CAPTA Require Reporting All Substance-Exposed Newborns to Child Protective Services?

No. CAPTA only requires 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[v]" affected by "withdrawal symptoms resulting from prenatal drug exposure" or having Fetal Alcohol Spectrum Disorder" (FASD).[vi] Such notifications or reports are *for the purpose of identifying whether the family is in need of care or services* ("to address the needs of infants").

Does CAPTA Require Mandated Reports to Take the Form of an Allegation of Child Abuse or Neglect?

No. The law specifically states that these reports are *not* for the purpose of redefining child neglect or abuse, nor for the purpose of accusing the mother of abuse or neglect, even when newborns receive a diagnosis of neonatal abstinence syndrome or FASD. In fact, it should be noted the purpose of the federal funds is to assist states in creating programs and services designed to help newborns and their families. CAPTA-based reports are not required to be, and should not be, treated in the same manner as a report of suspected neglect or abuse against a parent. CAPTA does not say that a baby's positive toxicology result is *per se* evidence of civil child neglect or abuse.[vii]

Does CAPTA Require States to Mandate CPS Involvement with All Babies After a Report?

No. CAPTA's grant eligibility criteria require state programs to include "the development of a plan of safe care" for infants identified as affected by substance abuse, withdrawal symptoms, or Fetal Alcohol Spectrum Disorder.[viii] It is up to individual states to determine when and if a plan is needed[ix] and which agency or entity (such as hospitals, community organizations, or a child protective services department that is established to receive CAPTA reports separate from reports of child neglect/abuse) is responsible for developing the plan of care.[x] It does not have to be and should not be the existing child welfare agency.

Ideally, states should create a separate reporting and data collection process outside the child welfare system to receive CAPTA reports. The federal funds can be used by states to develop a myriad of ways to offer confidential services and support to families after a baby has been identified in a report, outside of the context of a punitive child neglect investigation and proceeding. At a minimum, separate reporting and data collection processes should include a separate database, separate staff, and separate contact person/office. They could also include collaborating with another agency to collect the information and "notify" the child welfare agency. For example, the state's de-identified Pregnancy Risk Assessment Monitoring system could be used to collect data in the three enumerated categories.

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[i] Poland, et al., *Punishing Pregnant Drug Users: Enhancing the Flight From Care,* 31 Drug and Alcohol Dependence 199 (1993). *See also* Rosa Goldensohn & Rachel Levy, The State Where Giving Birth Can be Criminal, The Nation, Dec. 10, 2014, *available at* https://www.thenation.com/article/state-where-giving-birth-can-be-criminal/, (investigative report documenting that Tennessee's "fetal assault" law in effect from 2014-2016 caused pregnant women to avoid healthcare and flee the state to give birth).

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

[iii] 42 U.S.C. § 5106a (2017).

[iv] *Id.* Guidance issued by the Administration for Children and Families reiterates this and notes that, "It is ultimately the responsibility of CPS staff to assess the level of risk to the child and other children in the family and determine whether the circumstance constitutes child abuse or neglect under State law." U.S. Dep't of Health and Human Services, Admin. For Children and Families, *Mandatory Reporters of Child Abuse and Neglect,* (2015), *available at* https://www.childwelfare.gov/pubPDFs/manda.pdf#page=5&view=Summaries%20of%20State%20laws.

[v] It should be noted that CAPTA itself does not provide a definition of "affected by substance abuse." In guidance to CPS workers, the Office on Child Abuse and Neglect, which is responsible for administering programs under CAPTA, distinguishes between substance use and "substance use disorders," the term now used by most medical experts instead of "substance abuse." Substance use disorder is defined as: *A pattern of substance use that leads to significant impairment or distress, reflected by one or more of the following: Failure to fulfill major role obligations at work, school, or home (e.g. substance-related absences from work, suspension from school, neglect of a child's need for regular meals)*; *Continued use in spite of physical hazards (e.g., driving under the influence)*; *Trouble with the law (e.g. arrests for substance-related disorderly conduct); Interpersonal or social problems.* U.S. DEP'T OF HEALTH AND HUMAN SVCS. ADMINISTRATION FOR CHILDREN AND FAMILIES, PROTECTING CHILDREN IN FAMILIES AFFECTED BY SUBSTANCE USE DISORDERS (2009), *available at* https://www.childwelfare.gov/pubPDFs/substanceuse.pdf.

[vi] 42 U.S.C. § 5106a (2017).

[vii] While workplace drug testing is typically done in accordance with federal regulation and consistent standards, toxicology tests on pregnant women and newborns are not. The tests are often unconfirmed and not preserved for re-testing, so they are not reliable, nor do they provide information about drug dependency or parenting ability.

[viii] 42 U.S.C. § 5106a (2017).

[ix] Not every infant identified will need a plan of safe care following discharge from the hospital, as affects and withdrawal symptoms are often temporary and best treated with constant parent contact and breastfeeding. MacMillan, et al., *Association of Rooming-in With Outcomes for Neonatal Abstinence Syndrome, A Systematic Review and Meta-analysis,* JAMA Pediatr. 2018, available at https://jamanetwork.com/journals/jamapediatrics/fullarticle/2672042; Saiki, et al., *Neonatal Abstinence Syndrome-Postnatal Ward Versus Neonatal Unit Management*, 169 EUR. J. PEDS. 95 (2010); Welle-Strand, et al., *Breastfeeding Reduces the Need for Withdrawal Treatment in Opioid-Exposed Infants*, 102 FOUNDATION ACTA PAEDIATRICA 1060 (2013).

[x] U.S. Dep't of Health and Human Services, Admin. For Children and Families, *Mandatory Reporters of Child Abuse and Neglect,* (2015), *available at* https://www.childwelfare.gov/pubPDFs/manda.pdf#page=5&view=Summaries%20of%20State%20laws.

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Center for Family Representation (CFR)
Submitted Testimony for the Joint Hearing of the Committee on General Welfare and Committee on Hospitals

Hearing Date: April 10, 2019

Oversight - Impact of Marijuana Policies on Child Welfare

CFR is grateful for the opportunity to submit testimony to the Joint Hearing of the Committee on General Welfare and the Committee on Hospitals on the impact of marijuana policies on child welfare. We thank the Committees for their focus on this important issue.

Overview of CFR

CFR is the New York City county-wide assigned indigent defense provider for parents who are respondents in Family Court Act (FCA) Article 10 proceedings in Queens and New York counties. CFR was founded in 2002 to support indigent parents in raising their children safely and to minimize the City's reliance on foster care. Currently, pursuant to a contract with the New York City Mayor's Office of Criminal Justice (MOCJ), CFR represents on average 1,300 new clients each year in Article 10 proceedings, and in supplemental proceedings like custody, guardianship, visitation and termination of parental rights cases. We also provide representation on interim and final appeals. CFR has served over 9,000 families since our founding in 2002.

CFR employs an interdisciplinary model of representation, marrying in court litigation to out of court advocacy: every parent is assigned an attorney and a social work staff member beginning at intake, which is generally the first day a parent is summoned to court, and these teams are supported by parent advocates, paralegals and supervisors. In late 2015, the New York State Bar Association gave CFR its Award for Promoting Standards of Excellence in Mandated Representation, noting that CFR

"exemplifies and defines the highest professional practice standards, is a recognized innovator in parent representation and is a tireless advocate for legislative and policy reform." Additionally, the federal Administration for Children, Youth and Families specifically cited CFR in the addendum to its January 2017 Memorandum on High Quality Legal Representation, issued to all fifty states.

In recognition of the fact that parents who face a child welfare case also face multiple additional legal challenges outside of family court, which undermines their ability to raise their children safely, CFR launched *Home For Good*, with City Council support, a one-stop solution providing additional representation in immigration matters, criminal court and housing court. We also provide intensive assistance to recently reunified families in securing day care, school placement, public benefits and other services. Our goals are always to prevent foster care, or where foster care is unavoidable, to shorten the time children spend in care and to prevent re-entry into care.

Treatment of Marijuana Use in Family Court

In 2018, approximately 35 percent of respondents CFR was assigned to represent in New York and Queens counties faced allegations related to substance abuse. While CFR does not maintain statistics distinguishing between allegations of marijuana misuse and the abuse of alcohol or other drugs, in our experience, allegations relating to marijuana account for a large portion of these cases. Even as New York has recognized that the criminalization of marijuana disproportionately impacts communities of color and has taken steps towards its legalization, New York's child welfare system continues to exploit parents' marijuana use and possession as a basis to police families and separate children from their parents. The child welfare system's reliance on a parent's use of marijuana as the sole basis for involvement in the child welfare system, whether through a report to the State Central Registry ("SCR"), an investigation by the Administration for Children's Services ("ACS"), or the ultimate filing of a Petition against a parent in family court, continues to disproportionately impact communities of color.

At a hearing to discuss "Oversight - Parent Child Separation in Family Court," before the New York City Council Committees on Justice Systems and General Welfare on November 27, 2018, ACS commissioner David Hansell testified that ACS "never" uses marijuana as a basis for a removal or investigation. In CFR's experience, that is simply not the case. ACS Petitions sometime allege neglect based solely on a single positive drug screen or a parent's own admission that he/she smokes marijuana, without any further evidence that the parent's marijuana use poses any risk to the child. Additionally, even when marijuana use is not a primary allegation in a Petition, ACS may insist upon a lengthy period of a parent testing negative for marijuana before they will consider expanding contact between a parent and child, or reunification. In doing so, ACS regularly fails to distinguish between parents who simply use marijuana and parents whose misuse of marijuana has had some effect on their child. Despite changing marijuana policies in New York, ACS continues to use marijuana use as a tool to bring families into the child welfare system and New York City's family courts, as well as a justification to prevent reunification. As New York has taken steps to legalize marijuana and recognize that not all use of marijuana is abuse, ACS should amend its policies and enforcement to ensure that parents only get entangled in the child welfare system when a parent's abuse of marijuana places a child at risk of harm.

ACS relies on a parent's use of marijuana in various ways in New York family courts. While in some cases ACS alleges the use of marijuana by a parent as the only allegation in a neglect petition, in other cases an allegation of a parent's marijuana use is used to bolster an otherwise weak neglect petition, particularly when ACS seeks to remove a child from his/her parents. One example of this is the case of Ms. B, who CFR was assigned to represent in Queens Family Court during the fall of 2017. ACS alleged that Ms. B neglected her child by possessing marijuana while waiting for a shelter placement through the Department of Homeless Services and by smoking marijuana. The Petition did not allege how Ms. B's possession or use of marijuana posed any risk to her child. At intake, ACS

asked the Court for a removal order, which CFR opposed. The Court was adjourned for three days, during which time the child was removed from Ms. B and in the care of a kinship resource. When the parties returned to Court, ACS agreed to release the child to Ms. B, but only on the condition that she attend a substance abuse program. Ms. B agreed to engage in a substance abuse program and was eventually granted an adjournment in contemplation of dismissal. More than one year after the filing of the Petition, ACS continues to supervise Ms. B and her family. In our view and considering changing New York policy, Ms. B did not need a substance abuse program at all, and certainly did not need ACS and court oversight for this lengthy period of time.

Another example shows how ACS continues to use marijuana use as a tool to prosecute parents, even where a parent voluntarily engages in treatment for marijuana use at the behest of ACS in an attempt to work towards reunification. During the summer of 2018, ACS filed a petition against Mr. H in Queens Family Court alleging that he neglected his child by misusing marijuana and not being engaged in a drug treatment program, as well as by perpetrating acts of domestic violence against the mother while she was pregnant with the subject child. At the time of filing, ACS requested a remand and the child was placed in foster care. Following the filing of the Petition, Mr. H voluntarily engaged in a drug treatment program and began to submit to random drug screens at his program, as requested by ACS' service plan. In an attempt to bolster the neglect petition, ACS then sought to amend the petition to include positive tests for marijuana that Mr. H submitted to after he enrolled in the drug treatment program and after the child was placed in foster care.

ACS also regularly utilizes a parent's marijuana use and positive drug screens for marijuana as a barrier to reunification or liberalized contact between a parent and child. During a recent appearance in Manhattan Family Court, Ms. P requested unsupervised contact with her child for the purpose of walking him home from school, a walk that would take ten minutes at most. At the time, Ms. P was only permitted to have supervised visits with her child. ACS opposed the application based upon Ms. P

continuing to test positive for marijuana, even though her supervised visits were going well and she never appeared under the influence during her visits with her child. ACS did not raise any concerns other than Ms. P's positive drug screens for marijuana. In another example, ACS filed a neglect petition against Ms. T in 2018, alleging that she used marijuana while caring for and breastfeeding her child and that the child sustained a fracture to the shoulder. The child was released to Ms. T until ACS filed an abuse petition against her alleging that the shoulder fracture was caused by non-accidental trauma. Upon the filing of the abuse petition, Ms. T's child was removed from her care and she began having supervised visits with the child. At a subsequent court date, all counsel agreed and the Court granted ACS discretion to expand Ms. T's supervised visits to unsupervised visits. ACS repeatedly refused to expand Ms. T's visits to unsupervised visits based solely upon positive screens for marijuana, not any other safety concerns.

ACS also uses allegations of marijuana use to prevent non-respondent parents, who are not being alleged to have neglected their children, from caring for and having free access to their children. In Queens Family Court, ACS used a suspicion of marijuana use by a non-respondent parent as a basis for denying the non-respondent father's request to have the children released to him. ACS filed a petition against the respondent mother, Ms. C, based on allegations that she smoked marijuana, that her home was in an unkempt condition, and that one child had an unexplained injury. At intake, ACS sought a removal and the children were remanded to ACS and placed in foster care. Ms. C requested that the children be released to the non-respondent father, who expressed a desire to have the children reside with him. The non-respondent father's home was cleared by ACS, but ACS opposed the release to the non-respondent father because they believed he would test positive for marijuana because the Child Protective Specialist believed the home smelled like marijuana during the home visit. ACS did not raise any additional concerns regarding the non-respondent father. The children remained at the

Children's Center for nearly one month and were eventually placed in two separate non-kinship foster homes, before being returned to Ms. C's care following an emergency hearing.

These outcomes are not consistent with New York marijuana policies, or even ACS' own expressed policies, and continue to disproportionately impact communities of color. They demonstrate that ACS continues to rely solely on a parent's marijuana use in filing some neglect cases in family court, as well as in making decisions regarding recommendations on removals and reunification. ACS must re-examine its approach of relying on a parent's marijuana use to bring poor families of color into the child welfare system and establish policies to prevent the separation of children from their parents and the unnecessary supervision over and prolonged separation of families based solely on the parent's marijuana use.

Drug Testing and Reporting of Marijuana Use

Drug testing during ACS investigations as well as the testing of pregnant women and new mothers at hospitals perpetuates the policing of marijuana use among poor parents of color and often brings these parents under the supervision of ACS and into New York family courts. In CFR's experience, parents being investigated by ACS are regularly asked if they use marijuana and if they are willing to submit to a drug screen, even when the initial report made to the State Central Registry had no mention of marijuana or any other drug use. Without legal representation during ACS investigations, parents often feel forced to admit to marijuana use or submit to drug screens during investigations, under threats from child protective specialists and the fear that refusing to cooperate will lead ACS to take even more aggressive action, including the removal of their children and the filing of a case in family court. As discussed above, contrary to New York City's current policies on marijuana use, a parent's admission to smoking marijuana and/or positive drug screens for marijuana, are regularly used to pressure parents into sustained contact with the child welfare system, by

pressuring them to voluntarily cooperate with a drug treatment program and preventive services, or as a basis for neglect allegations in family court.

Drug testing of pregnant women and new mothers and the reporting of positive drug screens for marijuana to the SCR also disproportionately impacts women of color. The testing and reporting by both public and private hospitals, not only brings mothers of color disproportionately into contact with the child welfare system, but can also have lasting effects on these mothers' abilities to work and support their families for an extended period of time. The HHC "Corporate Policy for Urine Toxicology Testing in the Pregnant Woman During the Antepartum Period, Labor and Delivery and Postpartum," dated February 12, 2014, notes that a "positive toxicology test result is not an indication to report to the State Central Registry of Child Abuse and Maltreatment ("SCR") unless there is concern regarding the safety of other children in the home." However, contrary to the official HHC policy, CFR has represented numerous mothers where a report was called in to the SCR with no articulated safety concern other than a positive drug screen for marijuana. New York must strive to do better.

The reporting of new mothers to the SCR, based solely on a positive marijuana screen and without any other evidence of neglect, has lasting consequences for mothers. These reports not only bring many poor women of color unnecessarily into contact with ACS and New York family courts, but also often result in an "indicated" case in the SCR, which limits these mothers' opportunities, for a period of up to twenty eight years, to work for employers who work with children, including custodial and administrative jobs at hospitals or schools, as well as home health aide positions, and will prevent these mothers from serving as foster parents. This can have dire long-term consequences on a mother's ability to support her children and perpetuates the cycle of poverty that often leads back to the child welfare system and ACS involvement.

Recommendations

1. CFR is in support of Int 1161 to enhance reporting on the child welfare system. The proposed enhanced reporting will force ACS to confront the reality that a parent's marijuana use regularly provides the basis for a family's involvement in the child welfare system. This will increase awareness of how ACS is using marijuana use to interfere unnecessarily in the private family lives of communities of color and serve as a reminder that ACS should only be involved where it can be demonstrated that marijuana use is actively harming or placing children at risk of harm in their parents' care.
2. CFR is in support of Int 1426, which would require ACS to provide an annual report to the Mayor and Council with information regarding the number of patients who were referred to ACS for investigation as a result of a positive toxicology screen performed at a facility operated by NYCHHC. CFR calls upon City Council to expand the scope to require ACS to provide such a report regarding all hospitals, both public and private, if within the Council's legal authority. Reporting on all referrals for investigation from hospitals would allow Council to monitor not only how patients in HHC hospitals are being treated, but whether all New York City hospitals are treating patients comparably or whether patients are being treated differently across hospitals located in New York City.
3. The Council should adopt Resolution 740, which calls upon ACS to implement a policy finding that a person's mere possession or use of marijuana does not by itself create an imminent risk of harm to a child, warranting the child's removal. Additionally, ACS policy should also reflect that a positive drug screen for marijuana should not be used as the only basis for denying more liberal contact or reunification of a parent with his/her child. ACS policy should require a showing of harm or imminent risk of harm to deny a parent expanded contact with his/her child.

4. CFR is in support of Resolution 746. We believe that the New York State Department of Health should create clear and fair regulations for hospitals on drug testing those who are pregnant or giving birth. Hospitals should be required to inform patients of their rights, including the possibility of a report to the State Central Register if a patient tests positive, and patients should be required to give their informed consent in writing before they are drug tested. CFR would also welcome clear and fair regulations regarding the reporting of a positive drug screen for marijuana to the State Central Register. A positive toxicology screen for marijuana should not be the basis for a report to the State Central Register unless it is accompanied by a concern regarding the safety of a child.

Conclusion

We are grateful for the invaluable opportunity to share our thoughts about the impact of marijuana policies on the child welfare system and to hear from other stakeholders in this area. Thank you for your commitment to ensuring that New York's child welfare system more accurately represents New York's policies on marijuana use throughout the city and state. We look forward to being a part of this ongoing conversation. If you have any questions, please do not hesitate to reach out to CFR's Senior Staff Attorney of Policy & Government Affairs, Jennifer Feinberg, at jfeinberg@cfrny.org or 646-276-6385.

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Address: 177 Livingston Street, Brooklyn

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I represent: Rise

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I represent: Center for Constitutional Rights

Address: 666 Broadway

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Name: Machelle Allen, Chief Medical Officer, Senior Vice President

Address: _____

I represent: N.Y.C. Health + Hospitals

Address: _____

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I represent: THE BRONX DEFENDERS

Address: 360 E. 161st STREET, BRONX, NY

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Name: Jayne Cooper

Address: 199 Water St

I represent: The Legal Aid Society

Address: 199 Water St

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Name: BRIANNE RYER

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I represent: NEIGHBORHOOD DEFENDER SERVICE OF HARLEM

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Name: Greg Waltman

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I represent: [redacted] (1) G1Quantum one (1)

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