FAMILY SEPARATION IN THE MEDICAL SETTING

The Need for Informed Consent

MFP
MOVEMENT FOR FAMILY POWER

We are the Drug Policy Alliance.

JMACFORFAMILIES
ADVOCATE AND ORGANIZE FOR CHILD WELFARE TRANSFORMATION

The Bronx Defenders
Redefining public defense.

NOV. 24, 2019

ABOUT

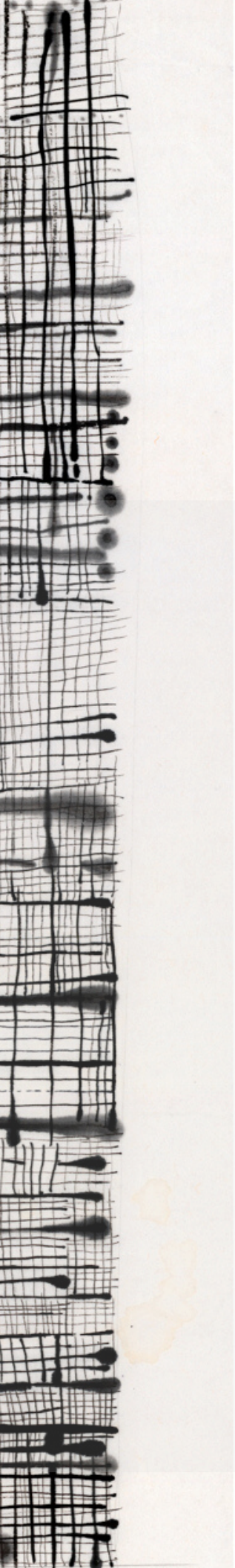
JMacForFamilies is a grassroots organization focusing on advocacy and organizing around the child welfare system and was founded by Joyce McMillan. Joyce was affected in 1999 and believes the separation of her and children created difficulties she and her daughters still work to overcome today. She knows first hand the changes needed to protect children, and her expertise in legislative and narrative change have fostered numerous culture and policy shifts in New York City.

JMacforfamilies supports finding alternatives to separating families by divesting in the foster care system, and actively rejects any alternative for families that acts as forms of punishment. Moreover, the organization envisions a world where best practices for family wellness will no longer rely on "slave master's mentality" of separating, policing and punishing when it comes to families of color. JMacForFamilies implements its work through legislative advocacy, political agitation, and the development of strategic coalitions, such as the Parent Legislative Action Network (PLAN).

Movement for Family Power works to end the Foster System's policing and punishing of families in order to create a world where the dignity and integrity of all families is valued and supported. Rooted in abolitionist principles and our elders, driven by movement lawyering, impacted people MFP carries out its work by: (1) Building out a loving, healthy community with and amongst people working to shrink the Foster System: (2) Raising social consciousness around the harms of the foster system to support the reclaiming and reimagining of Safe and Healthy Families; and (3) Disrupting and curtailing Foster System Pipelines, reducing the level of harm inflicted by forced family separations.

T**he Drug Policy Alliance** envisions a just society in which the use and regulation of drugs are grounded in science, compassion, health and human rights, in which people are no longer punished for what they put into their own bodies but only for crimes committed against others, and in which the fears, prejudices and punitive prohibitions of today are no more. Our mission is to advance those policies and attitudes that best reduce the harms of both drug use and drug prohibition, and to promote the autonomy of individuals over their minds and bodies. Learn more at drugpolicy.org.

The Bronx Defenders is a public defender non-profit that is transforming how low-income people in the Bronx are represented in the legal system, and, in doing so, is transforming the system itself. Through an integrated team-based structure that includes criminal, civil, immigration, and family defense attorneys, as well as social workers, benefits specialists, legal advocates, parent advocates, investigators, and team administrators, we have pioneered a nationally-recognized model of representation called holistic defense that achieves better outcomes for our clients. Our Family Defense Practice was created in 2005 and represents parents in child protection and all of the related family court proceedings that arise out of an abuse or neglect case, including custody, visitation, family offenses, and termination of parental rights.



FAMILY SEPARATION IN THE MEDICAL SETTING:

THE NEED FOR INFORMED CONSENT

A young Latinx woman stood outside one of the many New York Family Court rooms, slightly hunched over, clutching her midsection. She walked slowly and with purpose. Her face was contorted in a mix of pain, fear and determination. She explained to a court bailiff who seemed indifferent that she had a c-section just a few days ago. She did not have her baby in her arms. A mix of explanations came to mind—perhaps her baby was at home? Maybe a friend was holding her baby somewhere else? But then it was clear. She came to court just a few days after major surgery and child birth. In all likelihood, her newborn was removed from her care, and she was in court to contest the removal. Two attorneys who knew about this case talked about this woman. Turning to each other one asked, "Newborn positive tox? Emergency Removal?" The other responded "Yes." In quick exchange the other continued, "Do you think it was warranted?" and with resolution the attorney answered firmly, "One hundred percent, absolutely not. **We got the baby home. She was lucky."**

INTRODUCTION

Every day low income and Black and Brown pregnant and parenting New Yorkers are separated from their children or threatened with family separation, based on accusations of drug use alone.[i] These disruptions almost always begin with a call to Child Protective Services (CPS) by medical providers, and frequently occur after of a non-consensual urine toxicology conducted by the hospital staff returns positive for illicit substances. This routine practice of "test and report"[ii] normalizes the violation of pregnant people and their newborn's bodily autonomy and is inconsistent with treating substance use disorder as a health condition with social and behavioral dimensions. These practices are further complicated by the reality that those who are routinely tested are often our most marginalized community members. They are overwhelmingly people of color, who rely on State subsidies for treatment and care. [iii] In sum,

PREGNANT PEOPLE WHO USE DRUGS (PPUDS) EXIST AT THE INTERSECTIONS OF MEDICALIZATION, MORALIZATION, AND CRIMINALIZATION AND REQUIRE OUR MOST VIGILANT ATTENTION AND OUR MOST EXCEPTIONAL COMPASSION.

Demanding that pregnant people and their newborns have at **minimum** have knowledge of and give consent to the drug testing of their own body and children is a discrete but significant step forward in ensuring that all members of our community are treated with humanity. It decreases the punitive aspects of our current reporting practices which can ultimately threaten the health and wellbeing of both the new mother and newborn. This is why the American College of Obstetricians and Gynecologists (ACOG) opposes non-consensual drug testing and responding to drug use during pregnancy with punitive measures such as criminal prosecution or the threat of child removal.

ACOG states that:

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

IN HEALTHCARE SETTINGS PREGNANT PEOPLE WHO USE DRUGS CAN BE VILIFIED AND DEEMED UNFIT

and dangerous to their children based on their drug use alone.[v] The social stigma causes individuals to fear physicians, social workers and other medical providers and can discourage pregnant people from seeking or fully engaging in routine prenatal care or treatment for substance use disorder (SUD).[vi] Stigma, reinforced on a structural level, manifests in hospital drug testing and reporting policies that can lead to forced separation of the newborn and mother and family surveillance. In fact, according to 2017 data obtained from the Administration for Children's Services (ACS), at least one in four removals of children from their parents involved allegations of parental drug use. In the same year, 462 mothers from the Bronx were investigated for allegations of child maltreatment based on their drug use while pregnant, and almost 70% of these mothers had investigations indicated against them.[vii]

462 MOTHERS FROM THE BRONX WERE INVESTIGATED FOR ALLEGATIONS OF CHILD MALTREATMENT BASED ON THEIR DRUG USE WHILE PREGNANT, AND ALMOST 70% OF THESE MOTHERS HAD INVESTIGATIONS INDICATED AGAINST THEM

Biologic testing of pregnant people and newborns for the presence of licit and illicit substances is an institutional policy theoretically intended to promote public health. However, efforts to protect children from harm have expanded the surveillance responsibilities of actors who come into contact with families, health care workers, and social workers, as they must act as service providers and mandated reporters. The expansion of reporting obligations into the realm of reproductive health care makes seeking care a precarious endeavor. In practice, it exacerbates the "womb to foster care pipeline" which "pushes impoverished newborns... out of the womb and into the foster care system"[viii] and creates unnecessary barriers to the care that can improve health outcomes.

I. HISTORICAL EMERGENCE OF DRUG TESTING AS REPRODUCTIVE SURVEILLANCE

During the "crack epidemic" of the late 1980s and 90s, increased and often negative media and research attention was given to the experience of women who used cocaine. Researchers posited that unlike previous drug epidemics, women were more likely to be associated with crack use. As women's drug use was under increased scrutiny, the reproductive rights and caregiver roles of women who use drugs was a subject of political debate. Most famously, anti-abortion advocate and figurehead of the "Just Say No" campaign popularized this myth with propaganda that directly conflated parenting capacity and drug use with statements like, "Drugs steal away so much . . .They take and take until finally every time a drug goes into a child, something else is forced out, like love, and hope, trust and confidence."[ix]for the pregnant person and newborn.

During the War on Drugs, the population of parents and children under the foster system supervision and control increased sharply.[x] Hospitals were drug testing Black and Brown mothers at birth largely based on a grossly exaggerated "crack baby" mythology.[xi] At the same time, the federal government), poured unprecedented funds into reimbursing states for the costs of removing children from their mothers (with no comparable funding increase for reunification funds), and stagnated or decreased funds for basic necessities for families such as drug treatment and associated healthcare, housing, child care etc..[xii]

While the hysteria surrounding crack cocaine use eventually abated, and indeed was found to be unsupported by science[xiii], the policies and practices created during this era continue to inform how reproductive healthcare for people who use drugs are administered, and regulated. One such example is the rapid expansion state laws surveilling pregnant people via the Child Abuse Prevention and Treatment Act (CAPTA), and the Comprehension Addiction and Recovery Act (CARA) from 2002- 2018.[xiv]

Enacted in 1974, CAPTA provides federal funding to states to support the "prevention, assessment, investigation, prosecution, and treatment" of child abuse, in exchange for states' fulfillment of certain requirements.[xv] In the last twenty years CAPTA has been amended to require states to have policies in place to "notify" child welfare agencies of babies who fall into one of the three enumerated categories: being "affected by substance abuse" affected by "withdrawal symptoms resulting from prenatal drug exposure" or having Fetal Alcohol Spectrum Disorder" (FASD).[xvi] These notifications are neither child protective reports, nor are they requirements that hospitals drug test mothers or newborns.[xvii] However, studies confirm that that doctors frequently misunderstand their responsibility under CAPTA, and States have widely expanded the scope of this law further consecrating a practice of drug testing and reporting in hospital settings that is not legally required, and further that risks the wellbeing of parents and their newborns.[xviii]

II. DRUG TESTING: THE LEGAL AND HEALTH IMPLICATIONS

Social stigma, that reinforces the value and utility of criminalization as a deterrent to drug use, contributes to the creation of structural stigma; a set of policies and practices put in place by institutions to restrict the assistance or options available to the stigmatized groups.[xix] There is no greater example of structural stigma than the "drug test" as proxy for "good parenting." Selective drug-testing of pregnant or post-partum people and newborns create an opportunity for bias to inform who is subject to testing.

In an oft-cited case study wherein urine toxicology results were anonymously collected over a 6 month period, it was found that despite similar rates of substance use among Blacks and whites in the study, Black women were reported to social services at approximately 10 times the rate for white women, and low-income women were more likely than others to be reported.[xx] Considering the legal ramifications of a positive toxicology or assessment, it's imperative that patients be made aware of the health benefits as well as the legal consequences of submitting to a drug test, and be allowed to make informed decisions about their medical care.

Take for example the case of SF:

> Ms. FS a young Latinx woman who had been receiving methadone maintenance treatment for a long standing opiate addiction and was successfully engaging with treatment during her pregnancy. Although, methadone is a gold standard of care for pregnant women with opioid addictions, and while it is usually not recommended to taper methadone use during pregnancy, Ms. FS made the personal decision to do so because she felt it would decrease the duration of her newborn's withdrawal symptoms. Unfortunately, the tapering off methadone caused Ms. FS to experience painful withdrawal symptoms—symptoms, that when untreated, have been described by leading medical experts as torture. So in a moment of incredible pain, she decided to use heroin to gain some relief from the pain she was experiencing.
>
> When she went into labor, her OBGYN at St. Barnabas Hospital drug tested her and her newborn without her informed consent, and because she and her baby tested positive for opiates and methadone, they called ACS. Armed with the single positive opiate test, ACS brought Ms. FS and her family under court supervision. Although, ACS permitted her to remain with her three children it was under the condition that she never relapse or reuse, and fully comply with ACS demands which extended far beyond substance use treatment.
>
> Without a doubt, in the case of Ms. FS she had a substance use disorder. But also she was by all accounts a great mother to her older children, had committed to continuing treatment and her newborn had no long term effects of her use during pregnancy. Unfortunately, the child welfare system was not able to distinguish her substance use disorder, and instances of reuse and perhaps relapse, from whether she posed a risk to her children such that warrants the incredible harm of separating a child from their parents. And in their quest to "help" her, they inflicted incredible stress and harm to her.[xxi]

What Ms. FS experienced is not an isolated incident, nor is it an unusual response by the hospital or child protective services. While some forms of substance use can contribute to suboptimal[xxii] maternal and neonatal outcomes,

WHEN WOMEN LIKE MS. FS ARE TESTED AND REPORTED TO CPS, THE RELATIONSHIP WITH MEDICAL PROVIDERS IS OFTEN SEVERED, AND FUTURE ENGAGEMENT WITH MEDICAL PROVIDERS PRECIPITOUSLY DROPS.[XXIV] FURTHER, THE OVERSIGHT OVER HER FAMILY BECOMES THE COURT'S PRIORITY IN LIEU OF A TREATMENT INTERVENTION.

Even though there is no guarantee that if Ms. FS had been provided the opportunity to provide informed consent things would have definitely changed, it would have provided her the option to reach out to support networks for herself and family, and potentially eliminate the need for such intensive intrusion into her family. It may have also preserved a trusting relationship with her physician that could provide a long-term support for both mother and child.

III. NEW YORK POLICY ON DRUG TESTING

NewYork is one of nine states where evidence of a positive toxicology alone is not enough to substantiate a finding of child abuse or neglect. Rather, in addition to a positive toxicology, New York requires there to be evidence suggesting actual harm done to a child.[xxv] However, this does not prevent hospitals from creating their own internal policies and practices governing drug testing of expectant mothers. In 2012, New York Daily News published a story on drug testing new or expectant mothers in New York City Hospitals. The Daily News reported that more than a dozen NYC maternity wards routinely test expectant mothers, and this practice largely occurs in hospitals that serve primarily low-income mothers.[xxvi]

AN ANALYSIS OF CITYWIDE TESTING POLICIES SHOWED THAT ELEVEN CITY-RUN HOSPITALS TEST IF THE MOTHER HAS ADMITTED TO PAST DRUG USE OR SHOWS SIGNS OF "ABERRANT" BEHAVIOR. BROOKDALE HOSPITAL IN BROWNSVILLE, BROOKLYN TEST AT THE DISCRETION OF THE PHYSICIAN, AND HOSPITALS IN MORE AFFLUENT NEIGHBORHOODS TEST ON RARE OCCASIONS.[XXVII]

In 2014, New York City Health and Hospitals Corporation (HHC), which operates 11 hospitals, trauma centers and neighborhood health centers delivering services to more than a million New York City residents, published the sole unifying policy for its health care facilities regarding pregnancy and drug testing. The policy dictates that all pregnant and/or postpartum women who receive health services at any HHC facility must provide expressed consent to the medical provider prior to the performance of a toxicology test. The provider must also 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. If the mother refuses to consent, the refusal will be documented in her medical record. The policy expresses that a positive toxicology result is not an indication to report to the State Central Registry of Child Abuse and Maltreatment unless there is concern regarding the safety of other children in the home. [xxviii]

While this policy rests on the principle of informed consent, it fails in a myriad of ways. First, the informed consent memorandum is an internal document that is difficult to locate. Patients continue to be unaware of their rights prior to submitting to a drug test or screen. Secondly, the informed consent policy is expressed and given verbally. There is no documentation that indicates whether the attending physician or nurse communicated that they were going to perform a drug test on the patient or the newborn and whether or not the patient agreed to the test. Notably, when asked to testify about their drug testing policy at April 10, 2019 hearing at New York City Council, Health and Hospitals agreed specific and informed consent that was documented in the medical record for both the mother and newborn were critical and that healthcare providers should be providing

these protections.[xxix] However, family defender groups representing parents in New York City, and mothers impacted who have become vocal advocates like Shakira Kennedy, contend that it is common for their clients and their newborns to be drug tested at birth, often without their knowledge, without their informed consent, or even despite their explicit refusal.[xxx]

While the HHC policy is imperfect, it provides guidance to healthcare providers and protections to patients. Hospitals outside of New York City and out of the purview of HHC are left to develop their own guidelines or operate without guidance as there is no universal law or practice.[xxxi] The lack of uniform policy allows for biases and physicians discretion to inform a practice that can have long term deleterious effects on the patient and their families.

THE LACK OF UNIFORM POLICY ALLOWS FOR BIASES AND PHYSICIANS DISCRETION TO INFORM A PRACTICE THAT CAN HAVE LONG TERM DELETERIOUS EFFECTS ON THE PATIENT AND THEIR FAMILY.

CONCLUSION: INFORMED CONSENT AS BEST PRACTICE

Drug testing, especially covert drug testing, as a means of detecting substance use subverts the confidential relationship of trust that is at the heart of every successful medical care provider/patient relationship. Instead of biologic testing, physicians should consider relying on self-reporting. According to studies, self-reporting has been demonstrated repeatedly to be reliable in conditions where there is no motivation to lie, and in clinical settings where there are no negative consequences attached to truthful reporting.[xxxii] Moreover, if the desired goal is to achieve the best health outcomes for the mother and newborn, then the best practice would be to develop a trusting relationship with a patient, inform them of their rights, discuss relevant medical information which could include substance use history, and respond to the patient's needs if there is cause to, forgoing any report to child protective agencies. This is consistent with ACOG's recommendation that CPS report is not necessary where the only concern is a positive toxicology.

However, since many hospitals incorrectly interpret CAPTA requirements, the best and most ethical approach is to seek informed consent prior to testing and screening the patient and parent permission for the newborn. Informed consent allows for the patient to make decisions concerning their need to submit to a drug test having full knowledge of the medical benefits and legal risk associated with drug testing and reporting a potential positive toxicology. Informed consent also helps the medical care provider foster a trusting relationship with their patient and helps the patient to know what to expect in the course of receiving medical care. This helps the patient, their family and community prepare so that they, jointly with their medical care provider, can achieve the best outcome for their family.

[i] "Remarkably, U.S. families' engagement with the child welfare system is comparable in scale and concentration to the high levels of incarceration experienced by poor communities of color. Approximately one in three children nationwide—and up to half of Black children—experiences a CPS investigation during childhood." Fong, Kelley. "Concealment and Constraint" Child Protective Services Fears and Poor Mothers' Institutional Engagement, 4 June 2019 https://doi.org/10.1093/sf/soy093 Accessed 24 Nov. 2019.

[ii] Emma Ketteringham, "Test and Report: Bad for Children and Families," Huffington Post, Jun 25, 2014, https://www.huffpost.com/entry/test-and-report-bad-for-children-and-families_b_5175106?utm_hp_ref=politics; Ketteringham, Emma; Prince, Jessica; Venhuizen, Anne; Bronx Defender Services, New York City Council Joint Oversight Hearing on the Impact of Marijuana Policies on Child Welfare (2019) https://www.bronxdefenders.org/written-testimony-to-the-committee-on-general-welfare-impact-of-marijuana-policies-on-child-welfare/; Miriam Mack, Elizabeth Tuttle, "Parents Threatened with Losing Children over Cannabis Use," The Appeal, Sep. 9, 2019 https://theappeal.org/parents-threatened-with-losing-kids-over-cannabis-use/

[iii] Stone, Rebecca. "Pregnant Women and Substance Use: Fear, Stigma, and Barriers to Care." Health & Justice, vol. 3, no. 1, 12 Feb. 2015, link.springer.com/article/10.1186%2Fs40352-015-0015-5, 10.1186/s40352-015-0015-5. Accessed 19 Aug. 2019.

[iv] The American College of Obstetrics and Gynecologist, Substance Abuse Reporting and Pregnancy: The Role of the Obstetrician-Gynecologist, Jan. 2011. https://www.acog.org/-/media/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/co473.pdf?dmc=1&ts=20191125T0031426979.

[v] Ibid.

[vi] Emma S. Ketteringham, Sarah Cremer & Caitlin Becker, "Healthy Mothers, Healthy Babies: A Reproductive Justice Response to the "Womb-to-Foster-Care Pipeline", Cuny Law Review Vol. 20;https://academicworks.cuny.edu/clr/vol20/iss1/4; Fong, Kelley. "Concealment and Constraint" Child Protective Services Fears and Poor Mothers' Institutional Engagement, 4 June 2019 https://doi.org/10.1093/sf/soy093 Accessed 24 Nov. 2019.

[vii] Forthcoming research report by Movement for Family Power and NYU Law Family Defense Clinic; In New York State, local child protective services agencies (CPS) are required to investigate every allegation of child neglect or abuse received by the state SCR hotline. Under current New York law, if the child protective agency finds "some credible evidence" to support the allegations after an investigation, the report is deemed "indicated" and a caregiver's name is added to the SCR database, which can limit their employment opportunities for up to 28 years. With nearly 50,000 names added to the SCR in 2017 alone, hundreds of thousands of parents are blocked from a wide range of employment, including jobs at community centers, after school programs, drug counseling programs, transportation agencies, schools and home health service agencies. Thus the impact of reporting drug use, especially for pregnant people who use drugs, is far reaching. Currently a coalition of advocates, lead by Joyce McMillan, are working to reform this standard. As of November 24, 2019, A.8060-A/S.6427-A passed both houses and is awaiting the governor's signature.

[viii] Emma S. Ketteringham, Sarah Cremer & CaitlinBecker, “Healthy Mothers, Healthy Babies: A Reproductive Justice Response to the "Womb-to-Foster-Care Pipeline", Cuny LawReview Vol. 20 https://academicworks.cuny.edu/clr/vol20/iss1/4.

[ix] “Excerpts from Speech Halting Drug Abuse,” NewYork Times, September 15, 2019, https://timesmachine.nytimes.com/timesmachine/1986/09/15/188386.html?pageNumber=26

[x] There was one other point in US history when the US foster system experienced a similar spike in the number of children removedf rom their families. In 1977 503,000 children were in foster care. Leroy Pelton and others including Richard Wexler and Dorothy Roberts trace this sharp riseto federal financial incentives that provided a stream of money that states chose to use on foster care instead of assistance to poor families. Why did they make this choice? Public assistance roles were opening up to Black communities for the first time in American history, so rather than provide assistance the state provided foster care. Leroy Pelton, For Reason of Poverty: A CriticalAnalysis of the Public Child Welfare System in the United States (1989), pp.6-7, 10-13. Dorothy Roberts Shattered Bonds pages 174-177. Richard Wexler https://nccpr.org/a-child-welfare-timeline/

[xi] Michael Winerip, “Revisiting the ‘Crack Babies’ Epidemic That Was Not,” New York Times May 20, 2013, https://www.nytimes.com/2013/05/20/booming/revisiting-the-crack-babies-epidemic-that-was-not.html.

[xii] Numerous reports have analyzed the funding structure of foster care vs services. For ex: https://www.gao.gov/assets/160/153524.pdf ; Dorothy Roberts 173 Shattered Bonds

[xiii] Increased research on the impact of cocaine exposure on developing fetuses revealed that the impact of the substance was exaggerated and largely decontextualized. WOLFF, KRISTINA B. “Panic in the ER: Maternal Drug Use, the Right to Bodily Integrity, Privacy, and Informed Consent.” Politics & Policy, vol. 39, no. 5, Oct. 2011, pp. 679-714, onlinelibrary-wiley-com.ezproxy.cul.columbia.edu/doi/full/10.1111/j.1747-1346.2011.00313.x, 10.1111/j.1747-1346.2011.00313.x. Accessed 21 Aug. 2019.

[xiv] Thomas et al., “Drug Use During Pregnancy Policies in the United States from 1970 to 2016,” doi: 10.1177/0091450918790790.

[xv] 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

[xvi] 42 U.S.C. § 5106a (2017).

[xvii] Lloyd, et al., “Planning for safe care or widening the net?: A review and analysis of 51 states’ CAPTA policies addressing substance exposed infants.” Children and Youth Services Review Vol 99, 2019, pp 343-354, https://doi.org/10.1016/j.childyouth.2019.01.042.

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

[xix] Fonti, Siobhan, et al. “The Attitudes of Healthcare Professionals towards Women Using Illicit Substances in Pregnancy: A Cross-Sectional Study.” Women and Birth, vol. 29, no. 4, Aug. 2016, pp. 330-335, www-sciencedirect-com.ezproxy.cul.columbia.edu/science/article/pii/S1871519216000044, 10.1016/j.wombi.2016.01.001. Accessed 19 Aug. 2019.

[xx] “The Prevalence of Illicit-Drug or Alcohol Use during Pregnancy and Discrepancies in Mandatory Reporting in Pinellas County, Florida | NEJM.” New England Journal of Medicine, 2019, www-nejm-org.ezproxy.cul.columbia.edu/doi/full/10.1056/NEJM199004263221706. Accessed 21 Aug. 2019.

[xxi] Forthcoming research report by Movement for Family Power and NYU Law Family Defense Clinic.

[xxii] The exact impact of substance exposure is difficult to determine due to other relevant factors that influence healthy gestation such as nutrition, genetics, poverty, pre-existing medical conditions and access to appropriate medical care. WOLFF, KRISTINA B. “Panic in the ER: Maternal Drug Use, the Right to Bodily Integrity, Privacy, and Informed Consent.” Politics & Policy, vol. 39, no. 5, Oct. 2011, pp. 679-714.

[xxiii] Fonti, Siobhan, et al. “The Attitudes of Healthcare Professionals towards Women Using Illicit Substances in Pregnancy: A Cross-Sectional Study.” Women and Birth, vol. 29, no. 4, Aug. 2016, pp. 330-335, www-sciencedirect-com.ezproxy.cul.columbia.edu/science/article/pii/S1871519216000044, 10.1016/j.wombi.2016.01.001. Accessed 19 Aug. 2019.

[xxiv] Roberts, S.C.M. & Pies, C. Matern Child Health J (2011) 15: 333. https://doi.org/10.1007/s10995-010-0594-7

[xxv] CHILD WELFARE INFO. GATEWAY, PARENTAL DRUG USE AS CHILD ABUSE (2015), https://www.childwelfare.gov/pubPDFs/drugexposed.pdf. 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."

[xxvi] Yaniv, Oren. "Maternity Wards Test New Moms for Drugs." NY Daily News. N.p., 26 Dec. 2012. Web. <http://www.nydailynews.com/new-york/weed-dozen-city-maternity-wards-regularly-test-new-mothers-marijuana-drugs-article-1.1227292>.

[xxvii] Ibid

[xxviii] New York City Health and Hospital Corporations, Operating Procedure 180-8, Corporate Policy for Urine toxicology testing Pregnant Woman During the Antepartum Period, Labor and Delivery Postpartum, 2014

[xxix] https://councilnyc.viebit.com/player.php?hash=biao9dgYm1vx

[xxx] Natarajan, Nila Brooklyn Defender Services, New York City Council Joint Oversight Hearing on the Impact of Marijuana Policies on Child Welfare (2019)

[xxxi] Criminalizing Pregnancy Policing Pregnant Women Who Use Drugs In The USA, Amnesty International.

[xxxii] "Commentary on Friguls et Al. (2012): Illicit Drugs and Pregnancy - Testing ...: EBSCOhost." Columbia.Edu, 2012, web.b.ebscohost.com.ezproxy.cul.columbia.edu/ehost/detail/detail?vid=0&sid=b3ff6501-0b92-445e-b4edba77071f21%40sessionmgr103&bdata=JnNpdGU9ZWhvc3QtbGl2ZQ%3d%3d#AN=77633809&db=a2h. Accessed 3 Sept. 2019.