

Drug Tests Are Not Parenting Tests: The Fight to Reimagine Support for Pregnant People who Use Drugs





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Authors

Movement for Family Power

Informed Consent Campaign NYC

Bloom Collective

Indra Lusero

Reimagine Child Safety California

Maryland Office of the Public Defender

Jordan Dyett

Sarah Mering

Tristan Heart-Meyers

Editor

Elizabeth Brico

Elephant Circle

Drug Policy Alliance

Art

Jamie Harary

@CelestialHeartbreak

Design

Julia Wang

Gratitude

To all the mamas who have survived the family regulation system. We commit to nurturing better and more sustainable worlds.

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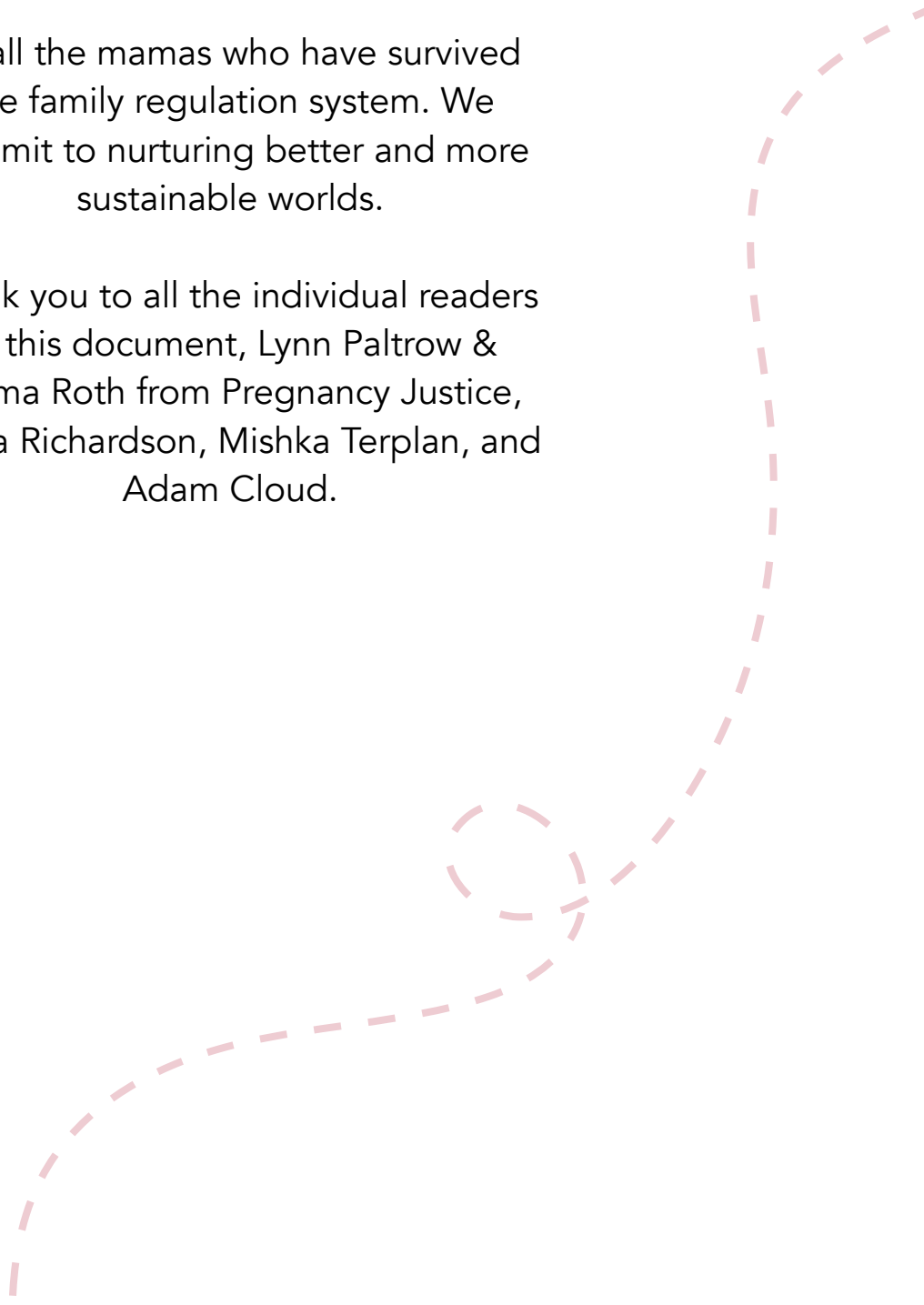


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I. Executive Summary

It is a universal truth that parents love and care for their children and want to do what is best for them. It should go without saying that this includes Black, Brown, Indigenous, and low-income parents. However, every day, Black, Brown, Indigenous and low income pregnant and parenting people are separated from their children or threatened with family separation based solely on accusations of drug use. These disruptions almost always begin with a report to Child Protective Services (CPS), hereafter referred to as the family regulation system (FRS) or family policing system.

Reports to FRS are often made by people who bear the responsibility to support families, with little to no acknowledgement on how these reports harm families and are connected to decades of social control. In the labor and delivery context, medical providers often call FRS after they have drug tested a new parent and their newborn without consent. This routine practice of “test and report” normalizes the violation of pregnant and postpartum people’s bodily autonomy as well as that of their newborns by testing their bodily fluids without their consent or knowledge. Worse yet, these test results are often used to impose surveillance and separation on families.

Many people confuse reports to FRS with support. However, communities impacted by reporting know better. The report starts a chain of events that results in increased family surveillance; beginning with invasive home visits and meetings with FRS caseworkers, court dates, and mandatory “services” such as observed urine drug tests and psychological evaluations to which caseworkers, judges, and attorneys are given access. During FRS investigations, FRS agents demand compliance with a list of requirements to prove parental “fitness.” When these stringent requirements are not met, and often even when they are, children are removed from their homes and placed in the care of extended family or strangers. What’s worse is that because FRS cases are considered civil actions, families are not afforded the admittedly lacking but still more substantial protections available in criminal cases, leaving their fates wholly in the hands of individual judges and case workers.¹ This means that the allegedly “benign” drug test and subsequent reporting, can lead to a stressful investigation and potentially unchecked judicial proceedings with the power to permanently dissolve families.

These issues are exacerbated by cultures of criminalization. Medical providers hyper-criminalize pregnant people who use drugs and, as such, pregnant and parenting people are very likely to be criminalized when they give birth. For example between 2011-2017 reports to FRS in the Bronx for substance use increased by nearly 20 percent when the person was pregnant.²

In other words, a person's reproductive choice, not merely substance use, was the heightened risk factor for family policing. Pregnant and parenting people who use drugs understand this. They know that their drug use is scrutinized differently because they sit at the intersection of maternal blame, racism, classism and War on Drugs rhetoric.

The truth is, substance use occurs on a spectrum and the majority of people who use drugs are able to moderate their use, a reality that is unchanged by pregnancy and parenthood. This is recognized by mainstream society when it comes to wealthy white people³ for example,⁴ the use of psychedelics,⁵ and cannabis products for nausea during pregnancy, however Black, Brown, Indigenous and low-income continue to be criminalized for the same use. However, even in those instances when a parent may genuinely have a substance use disorder (SUD) or when there is harm, the response from FRS does not treat SUD as a health condition with social and behavioral dimensions nor does it prevent harm. Instead, it responds with punitive measures that are not grounded in evidence-based solutions and could increase the risk of overdose and death.⁶

We must treat pregnant and parenting people who use drugs with dignity and respect. We must stop the flagrant use of drug testing without medical indication. If a drug test is needed, we must only administer tests or drug screens after obtaining meaningful, voluntary, and informed consent, including clear and concise written consent with opportunities for people to seek outside advice and support. We must also honor when patients refuse tests that are not medically necessary. The stakes are too high to do anything else.

Demanding that pregnant people have, at minimum, knowledge and consent to the drug testing of their bodies and their children's bodies is a simple but significant step forward in ensuring that all community members are treated as human beings with inherent value and autonomy. It decreases the punitive aspects of our current reporting practices, which can ultimately threaten the health and wellbeing of both the new parent, their infant, and the whole family. This is an easy step that all policymakers can take to begin supporting pregnant and parenting people. However, this will not be enough.

Legislators must be willing to decriminalize drug use by parents. They must work to end all laws that create barriers between pregnant people and new parents' access to safe, effective, and trustworthy healthcare. They must work to repeal the Child Abuse Prevention and Treatment Act (CAPTA), disincentivize medically unnecessary drug testing, eliminate criminal and civil penalties for pregnant people who use drugs, eliminate mandated reporting, and provide direct financial investment to communities. They must also do the internal work to train themselves out of biases that were ingrained by the War on Drugs. These are necessary steps towards building trust, restoring autonomy to parents and communities, and caring for those who have been subjected to and stigmatized by systems of control such as FRS and the drug war. Without these efforts, legislators will render informed consent meaningless.

This report is an effort to highlight efforts and actions that can be taken to end the War on Drugs on families. It starts with a historical framing of FRS to provide context on the punitive nature of FRS laws. It also argues that this historical framing must be a part of the legislative history if the goal is to repair the history of family separation policies. It then moves on to highlight state informed consent bills, national organizing efforts and efforts legislators must support to build out support, not separation.

II. Drug Testing & Reporting:

A Tool of Reproductive Oppression at the Margins

The US has a long history of family separation policies including but not limited to, chattel slavery, the colonization of Indigenous people, global war, evictions, oppressive welfare policies, deportations, and prisons. FRS is not an exception to the history of U.S. carceral logic, but rather inexorably connected to centuries of anti-Black, imperial and ableist policy making. This section aims to contextualize the demand to end “test and report” practices within a broader history of FRS. Additionally, it is the hope that the historical elements of this section become adopted into the legislative record, to guide the intent of any future law making.

Policy making must take into account both the present and future needs of constituents as well as the historical framing which ushered in the need for legislation. Absent a firm understanding of the past, laws can undermine the needs of the people. While it is clear that there is no single law that can fix all past and present harms, laws should be accountable to communities and firmly rooted in history. We encourage legislators not only adopt the changes in the law but to also draft legislative intent to which make clear the historical needs for legislative changes.

A. THE FAMILY REGULATION SYSTEM IS A SYSTEM OF ASSIMILATION, NOT SUPPORT

The first supervised FRS projects were the “Orphan Trains”—which took “orphaned” children from New York to live and work for white settlers in western U.S. The project was presented as a way to provide caring homes for unhoused children in New York, but in actuality, allowed for forced assimilation and labor of children, many of which were not orphans, but children of single parents. Charles Loring Brace, the founder of the Children’s Aid Society of New York, argued that sending immigrant offspring to America’s heartland would “civilize them” and satisfy the demand from farmers who needed workers to advance colonization in the West.⁷ The Orphan Train Project displaced 200,000 children from New York across the Midwest and stripped them of their cultural and religious identities. This project also grew alongside the eugenics movement, and as such incorporated and embedded ideologies which normalized reproductive manipulation.⁸ Over time, the project began to gain criticism, as it became clear that success stories were rare, and many children were indentured workers who received little [care](#).⁹

While the Orphan Train focused on unhoused immigrant children, who would in later decades racialize as white people, Black, and Indigenous families faced more punitive family separation tools designed to reinforce white supremacy and eliminate Indigenous people. For Black families, the institution of slavery introduced the mechanism of family separation and family policing. It is estimated that one-third of enslaved families were separated by the laws of chattel slavery.¹⁰ After emancipation, Black families were not subject to Orphan trains, as Black kids were more likely to be placed in jails or deemed delinquent. Similarly, the history of the Orphan Train does not encompass the persistent colonial threats during the nation-building project of the United States that separated Indigenous families. FRS system would continue the legacy of settler colonialism through the 1970s by stealing children from Indigenous families and forcing them into “boarding schools” then later placing the children up for adoption by white families.¹¹

B. SEGREGATIONIST POLICIES BUILT THE WELFARE AND FOSTER SYSTEMS

While orphan trains, settler colonialism, eugenics and slavery carved out the political container for current FRS laws, the actual construction of modern-day policies are a result of segregation and financial divestment strategies off Black communities. This section explains how racist backlash against the civil rights movement resulted in building the largest open-ended entitlement program which requires family separation i.e. the foster system.¹²

In 1935, the funding mechanism for the foster system became federalized through the Social Security Act, which encouraged states to establish FRS agencies and programs. Politicians lobbied to eliminate Black people from becoming eligible to apply for those benefits,¹³ and as a result, the only publicly available financial support for Black families was public assistance/welfare. This ushered in a two-tiered public benefit system which reflected racial attitudes of white superiority, and also allowed for targeted attacks on Black social support networks. As a result of this stratified benefits system, politicians were able to campaign against welfare while connecting it to larger segregationist narratives resulting in “Black women [bearing] the brunt of white anger at the increasing public welfare costs.”¹⁴ This politically designed connection between public benefits and Black caretakers utilized racial and sexualized tropes of Black femmes to fuel the public perception that Black mamas were in the “business” of baby-making to get money from the government and paved the way for “suitable home” laws which morph into the foster system.¹⁵


Suitable home laws were targeted at Black mamas who were largely locked out of the institution of marriage at that time. Specifically, they:

required that all children receiving public funds should be reared in homes that would make them useful and productive citizens of the state. Both acts provided that in no instance shall assistance be granted to any person who is living with his or her mother if the mother has had an illegitimate child after a check has been received from the Welfare Department, unless and until proof satisfactory to the parish Board of Public Welfare has been presented showing that the mother has ceased illicit relationships and is maintaining a suitable home for the child or children.¹⁶

These suitable home laws transferred responsibility to assess “suitability” to state child welfare agencies. Caseworkers had to make home visits, ask invasive questions regarding the fitness of the caretaker and submit memos to courts to determine whether parents (primarily Black mothers) would get social assistance. The design of these assessments was to eliminate as many Black mothers from receiving cash support as possible while simultaneously forcing a public record about morality based on white middle-class standards. When mamas were cut off from public assistance, they were then subject to child removals.¹⁷ These laws directly connected “legitimacy” and “worthiness” with public assistance, and were a tactic utilized by segregationists not only to denigrate Black families but to fight large-scale integration efforts more generally.

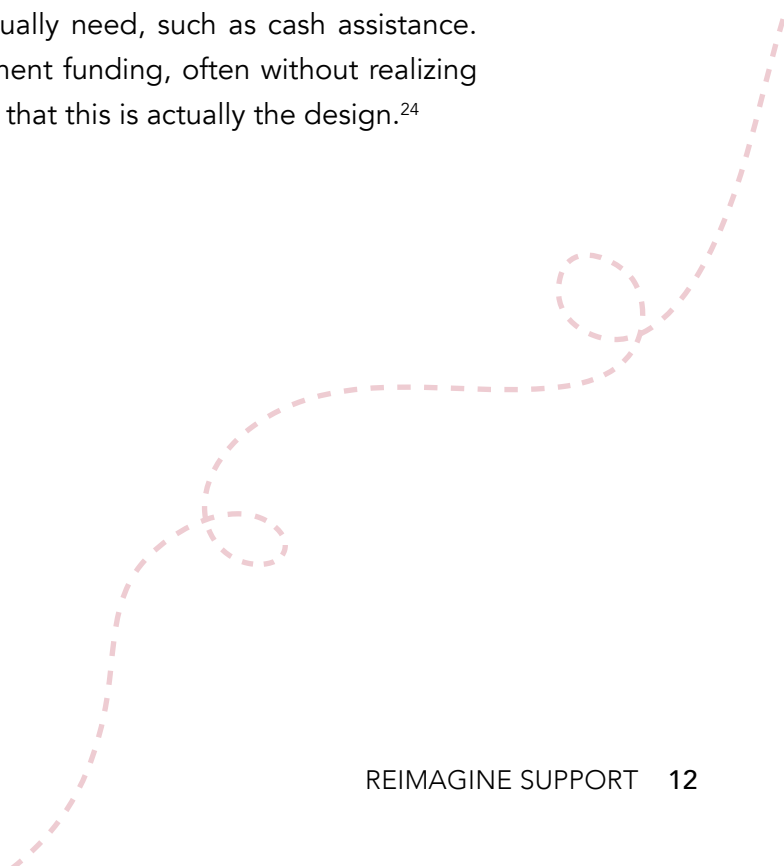
In the 1960s, the organizing of demands of the Civil Rights movement required the U.S. to reckon with the humanity of Black people on many levels—one such example is the desire to desegregate public schools.¹⁸ Segregationists adamantly fought school integration and utilized public attacks on Black mamas to make the case that white children should be separated from poorly raised Black children. Suitable home laws were the perfect political tool to make the case that Black families were inferior and should not be allowed to exist alongside white people.

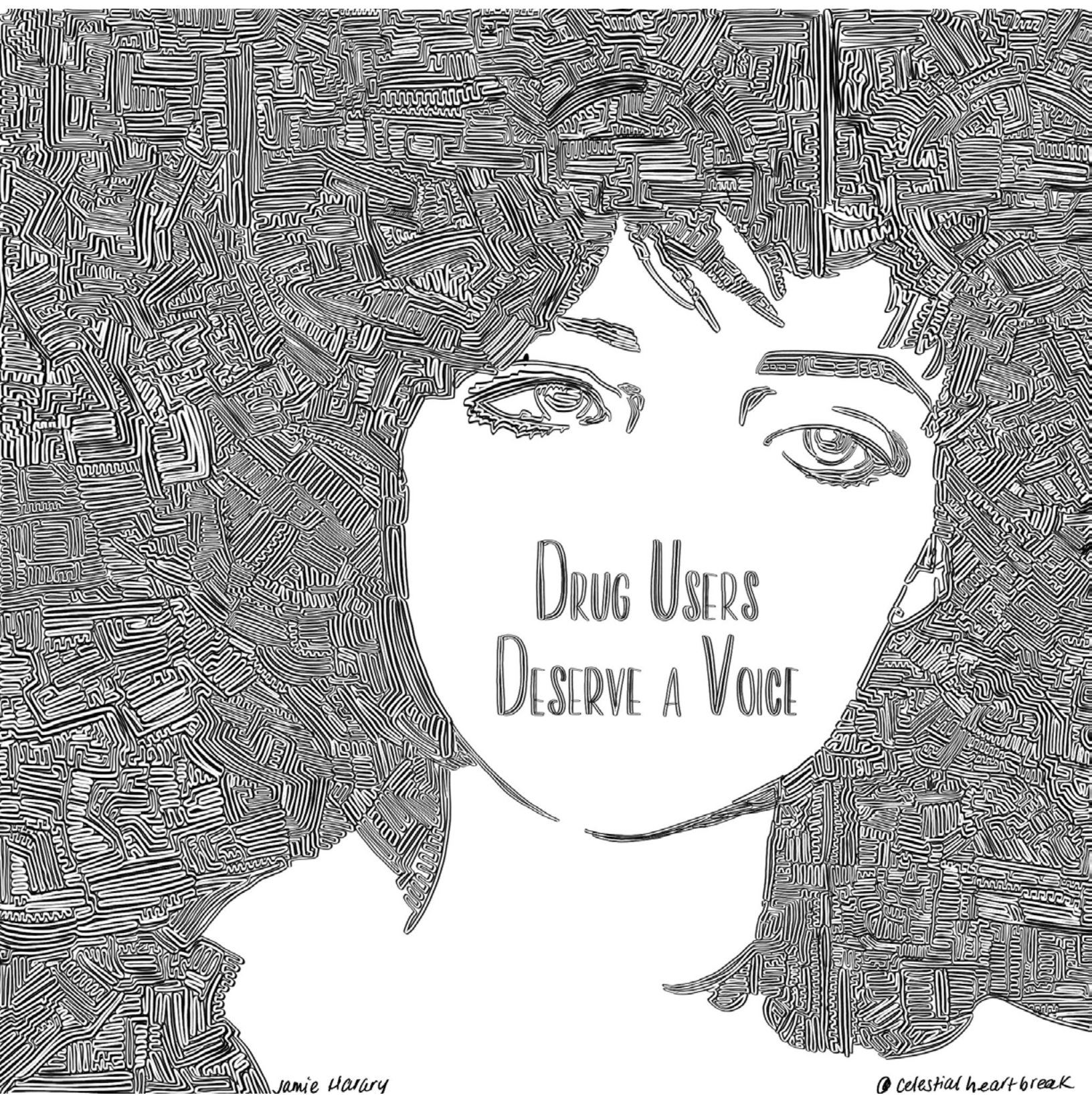
Even more cruelly, segregationists used suitable home laws to functionally segregate their states by starving out Black families so they would migrate to northern states with friendlier laws. Segregationist legislators were effectively starving Black children while blaming their Black mamas for political gain.¹⁹ This crisis became so profound that international aid had to be sent to Southern states to provide food for Black kids. Organizers appealed to the Federal government to deem these practices unconstitutional, however, states did have the constitutional authority to manage their own child welfare agencies and state funds.²⁰ To work around this issue, Arthur Flemming created an administrative loophole that would reshape public assistance and the foster system forever. Flemming conceded that states could deny Black caretakers welfare benefits but could not leave children without financial support simply because their caretakers were unsuitable.²¹



Instead, the “Flemming Rule” required states to provide “services” to make a home suitable or remove the child to “suitable” care while providing financial [support](#) to the child.²² This was a political turning point, policymakers chose to remove children rather than support families, and they have not looked back.

While the Flemming Rule did not explicitly give states the power to criminalize and punish Black families, the flexibility of the policy allowed the foster system to be utilized as a tool against the protection of Black, Brown, and Indigenous families.²³ The Flemming Rule introduced the foster system to the Aid to Dependent Children program and founded an economic structure where the resources to support families had to be connected with an assessment of “suitability” and family separation. With this rule in place, states receive federal matching funds for payments made on behalf of children removed from homes deemed unfit while there are no comparable funds for children who remain in their homes. This scheme sounds like the foster system because it is. The Flemming Rule has now been normalized. Though it was a response to segregationist tactics, applied in the context of FRS it reinforced disparate treatment of Black, Brown, and Indigenous families. People now accept that federal funds should be denied to children raised by “unsuitable” parents and that such funding should support family separation. People have now normalized that socialization and assimilation “services” should be given to caretakers versus things that families actually need, such as cash assistance. Policymakers accept this flow of government funding, often without realizing that it is divesting from Black parents and that this is actually the design.²⁴





DRUG USERS DESERVE A VOICE

Jamie Harary

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C. FROM WELFARE TO WAR: THE CRIMINALIZATION, VILLAINIZATION, AND SEPARATION OF BLACK FAMILIES

As described in the last two subsections, the historical origins of FRS have always been about maintaining white racial dominance, and more recently have been strategies to divest public funds from Black mamas. Policy makers must understand that hospital drug testing policies and subsequent reporting to FRS are born of these same histories, while also being a part of the anti-Black tactics designed by the War on Drugs.

When the War on Drugs began, the population of parents and children under the surveillance and control of the FRS increased sharply, with the starkest increases occurring among Black and Indigenous parents and children. There was a convergence of neoliberal and anti-black and anti-indigenous policies that encouraged this surge—such as the enactment of the Child Abuse Prevention and Treatment Act (CAPTA) which required states to enact mandatory reporting systems and policies and the increased practice of drug testing Black and Brown mothers at birth, primarily based on a grossly exaggerated “crack baby” mythology.²⁵

At the same time, the federal government poured unprecedented funds into reimbursing states for the costs of removing children from their mamas (with no comparable funding increase for reunification funds) and stagnated or decreased funds for necessities for families such as drug treatment and associated healthcare, housing, child care, etc. In fact, CAPTA replaced a policy that would have created a childcare entitlement, which had bipartisan support but was vetoed by Nixon as part of this divestment campaign.²⁶

While the hysteria surrounding crack cocaine use was eventually found to be unsupported by [science](#),²⁷ the policies and procedures the medical community and FRS created during this era continue to inform how reproductive healthcare for people who use drugs is administered and regulated. One such example is the rapid expansion of the CAPTA and the Comprehensive Addiction and

Recovery Act (CARA) from [2002-2018](#).²⁸ The targeting of parenting people who use drugs also extended to the administration of social service benefits when Congress passed the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) in 1996. This legislation greatly affected the ability of people who used drugs to care for their families. Drug testing implemented by PRWORA disproportionately targeted low-income families and kept them from receiving benefits, making them more susceptible to child removal. At the same time, the US made it harder for families to access benefits; we saw federal funding for removing children from their homes increase by approximately [20,000%](#) (from 1982 to 2003) and simultaneously the increase of federal drug control funding increased by nearly 400%. Surveillance became the norm, and as prison rates grew, so did child removals.²⁹

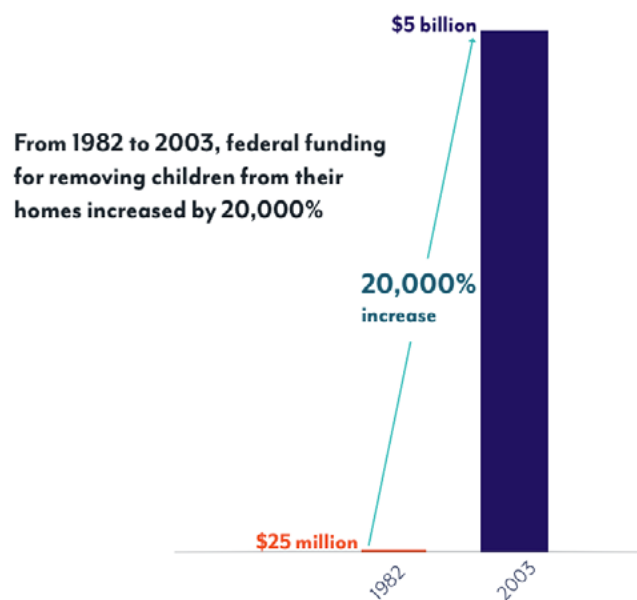


Figure 1: Graph from Movement for Family Power Report, "[Whatever They Do, I'm Her Comfort, I'm Her Protector: How the Foster System Has Become Ground Zero for the U.S. Drug War](#)", pg 18

From [1986](#) to 1996, the rate of children moved from their homes to the foster system increased by over 100%.³⁰ This simultaneous escalation of the family regulation and criminal legal systems calls back to the origins of FRS, where the primary goal was exploitation or elimination, and Black enslaved people and Indigenous people faced near-constant threats of family separation.

III. Surveillance is not Support:


Drug Testing & the Criminalization of Pregnant & Parenting People

In the past 40 years, hospitals have incorporated drug war tactics both in the treatment of their patients and in their practices. One clear example is the overreliance on drug testing, especially for Black, Indigenous, and other People of Color (BIPOC) parents and their newborns.³¹ According to a [recent study](#), Black kids have 172% higher odds of being drug tested at birth.³² As mentioned above this reliance on drug war tactics has more to do with legitimizing racial hierarchies than addressing potentially problematic drug use. Additionally, it was a tool to shame families away from help and extended the U.S. tradition of stigmatizing people who relied on public benefits.

The truth is that, parents who use drugs love their children and want the best for their bodies and families. They are human beings whose inherent value is not affected by the substances they use, the manner or frequency with which they use them, or any other matter related to substance use. Relying on drug tests—especially non-consensual drug tests—has enormous social consequences which far outweigh the tepid medical utility.

A. A DRUG TEST IS NOT A PARENTING TEST: THE SOCIAL LIMITS OF DRUG TESTS

Substance use can exist on a spectrum from occasional, recreational, frequent, to chaotic, with individuals experiencing different levels of usage at different times based on external factors, including stress, chronic pain, or traumatic [events](#).³³ The criminalization and stigmatization of substance use prevents people from seeking help and support when substance use shifts into chaotic use due to fear of penalization. This fear increases the risk of prolonged chaotic substance use, which can negatively affect a person's mental and physical health, as well as their relationships and responsibilities as a parent, community member, and employee.³⁴



In healthcare settings, pregnant people who use drugs are often vilified and deemed unfit or dangerous to their children based on their drug use alone. This social stigma causes individuals to fear physicians, social workers, and other healthcare providers, and often discourages pregnant people from engaging in routine prenatal care or, when there is an actual substance use [disorder](#), from seeking treatment.³⁵ This is why the American College of Obstetricians and Gynecologists (ACOG) opposes non-consensual drug testing and punitive responses to drug use during pregnancy such as criminal prosecution or the threat of child removal. [ACOG states](#):


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 [use] 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 [use] and addiction.³⁶

This statement is consistent with a recent [study](#) discussing how the stigma imposed on pregnant and postpartum parents who use substances increases their risk of overdose following birth.³⁷ A [follow-up study](#) displayed the positive effects of parental bonding on mother and child health.³⁸ These studies all show that drug testing does not end substance use but rather exposes families to avoidable risks.




Surveillance systems, like FRS, humiliate people, erode their autonomy and dignity, invade private relationships between providers and patients, and impose significant financial and time [burdens](#).³⁹

Drug testing increases risks to enter or re-enter systems of punishment like FRS and criminal legal systems.



It is essential that pregnant and parenting people have a trusting and confidential relationship with their provider. They must be able to ask questions and seek guidance without fear of retaliation or of being reported. Defying the importance of this relationship through medically unnecessary and non-consensual drug testing puts the health of individuals and their children at [risk](#).⁴⁰

Additionally, it reinforces “mother blame,” a term defined in *The Ethics of Perinatal Care for Black Women* as “holding pregnant women exclusively responsible for the ill health of children”.⁴¹ “Mother blame” places disproportionate focus on the behaviors of pregnant people as the only factors that impact the health of children, despite the knowledge that social determinants of health before, during, and after birth affect a child’s health into the future.⁴² Drug testing pregnant people and babies play into this “mother blame” narrative by placing myopic focus on a single action of the pregnant person as the sole determinant of a child’s health while disregarding the benefits of maternal bonding and other determinants of a child’s health. It also promotes the loss of family connections and removal from the social safety net, all of which cause harm to people who use drugs and their families, and could [increase substance use and worsen health](#).⁴³ By inserting surveillance into major essential areas of the lives of people who use drugs, policymakers are choosing to alienate them instead of helping to build trusting connections between health and service providers.



Drug testing a parent and their infant stands in direct opposition to the role a healthcare provider should play in the lives of a new parent, their child, and their family as a whole, who are all affected by this single action. A care provider should not introduce further trauma into a patient’s life, but the practice of “test and report” does just that. The practice of “test and report,” along with FRS involvement, creates cycles of foster system involvement and intergenerational trauma in communities that span generations.⁴⁴



B. THE MEDICAL LIMITS OF DRUG TESTS

Drug testing is a practice that is not built on medical necessity, but rather the long history of using drug tests as a surveillance tool, a practice that gained prevalence in US policy during the 1970s.

Widespread drug testing monitors, controls, and criminalizes many people across the US, but has the most significant interaction rates with low- and no- income Black, Brown, and Indigenous people who are more likely to be tested and reported.⁴⁵

Postpartum drug testing, in particular, targets parents and infants at a vulnerable time when necessary bonding and recovery should occur.

Drug tests are means of detecting the substances and/or substance metabolites present in a biological sample such as hair, blood, or urine at a particular point in time. The most common type of drug tests are immunoassay tests.⁴⁶ The

quality of these tests and the information obtained is poor and requires further testing to confirm results. Nonetheless, confirmatory tests are rarely performed before FRS intervenes on the basis of an initial positive result. High rates of false-positives are common with immunoassay tests due to cross-reactivity between substances, including common prescribed and over-the-counter medications that show up as illicit drugs like Sudafed, Robitussin, and Ibuprofen. Even poppy seeds can trigger an opiate positive if eaten close enough to the time the sample was taken.⁴⁷ Definitive results require additional testing, and while labs are able to detect and measure specific substances, there is simply no drug test that can, by itself, conclusively determine whether or not someone has a substance use disorder (SUD).⁴⁸

Utilizing drug testing as the default tool to identify substance use disorders relies on the assumption that any drug use is problematic even though the vast majority of substance use across all drug types is episodic and does not develop into a substance use [disorder](#).⁴⁹

A drug test is a limited technology that cannot indicate how much of a substance a person used, if a person is currently intoxicated, or if they meet the criteria for [SUD](#).⁵⁰

In the case that someone is experiencing a SUD, testing can be stigmatizing; often these tests are obtained or performed in ways that cause harm, such as using patient samples for testing without their knowledge or consent, observed urine tests that force patients to urinate while being watched even if they have a history of sexual assault or anxiety, or come with harsh and judgmental consequences like FRS involvement or forced inpatient programs. All of this reduces people's willingness to engage with healthcare systems. Moreover, they eliminate vital healthcare for the child, the parent. When children are born, we know that one of the best medicines a new baby can have is contact with their birthing parent.⁵¹ This does not change when a parent uses drugs. To the contrary, studies confirm that children who are experiencing physical symptoms from in-utero exposure to substance use actually benefit from being with their birthing parent.⁵²

IV. The Urgent Need to End “Test and Report” Practices

Across the country advocates are championing efforts to make sure families can be together and end the “test and report” practices. These efforts are led by people who use drugs, medical professional, activists and advocates alike. Policy-makers must listen to these demands if they seek to repair historical harms, and build structures of support.

A. STATE EFFORTS TO DEMAND INFORMED CONSENT PRIOR TO DRUG TESTING

Several states are working to curb the criminalizing impact of drug testing on pregnant people and their newborns by demanding that medical providers obtain meaningful consent prior to drug testing pregnant people.

It is important to note that the obligation to provide informed consent is already a part of medical provider ethics and the law. Advocates are asking for uniformity in the rights that already exists for patients and demanding power as they do it.

These state policies can all be enacted swiftly. There is no federal barrier to mandated informed consent, in fact there is no federal barrier to ending “test and report practices” more generally.

The Child Abuse Prevention and Treatment Act (CAPTA) does not require hospitals to report substance-exposed newborns to FRS. States can eliminate these policies immediately while federal advocates work to eliminate CAPTA completely.

CAPTA requires states to have a notification process to FRS in place, but these notifications are intended to identify whether the family requires care or

services. These notifications are not synonymous with neglect or abuse reports, which trigger investigations that can lead to surveillance, mandated compliance with inappropriate services, and family separation. These notifications are intended to help the state “determine whether and in what manner local entities are providing, following state requirements, referrals to and delivery of appropriate services.”⁵³ Furthermore, CAPTA does not require states to involve FRS in the plan of safe care but instead requires programs that include “the development of a plan of safe care” for infants identified as affected by substance use, withdrawal symptoms, or Fetal Alcohol Spectrum Disorder. Each state determines the nature of a plan of safe care. There is no federal requirement for states to rely on the existing FRS system.⁵⁴



This section highlights three campaigns that are working to build awareness among the general population, power to the affected communities, and change to the practices around informed consent for pregnant and parenting people.

I. NEW YORK DEMAND FOR INFORMED CONSENT

[Advocates in New York](#) are working to eliminate the womb to foster system pipeline⁵⁵ and are demanding that medical providers obtain informed consent prior to drug testing and/or screening birthing parents or their infants.⁵⁶ These demands are in response to decades of hospital-initiated child removals, often triggered by [non-consensual drug tests](#).⁵⁷ The fight for informed consent in New York is well grounded in existing legal frameworks. Specifically, the highest court has already determined that a positive toxicology test alone does not prove neglect, regardless of the substance used,⁵⁸ and the New York State department of health,⁵⁹ already requires hospitals to develop policies and procedures for obtaining informed consent prior to a substance use assessment. However, despite this seemingly progressive landscape pregnancy and drug use has been one of the highest indicators that a parent will come under FRS surveillance.



From 2011 to 2017, investigations that involved drug use were indicated at a higher rate than other investigations. Investigations that involved prenatal drug use were indicated at almost 2x the rate of non-drug use related investigations.

- % of indicated investigations
- % of indicated drug use investigations
- % of indicated prenatal drug use investigations

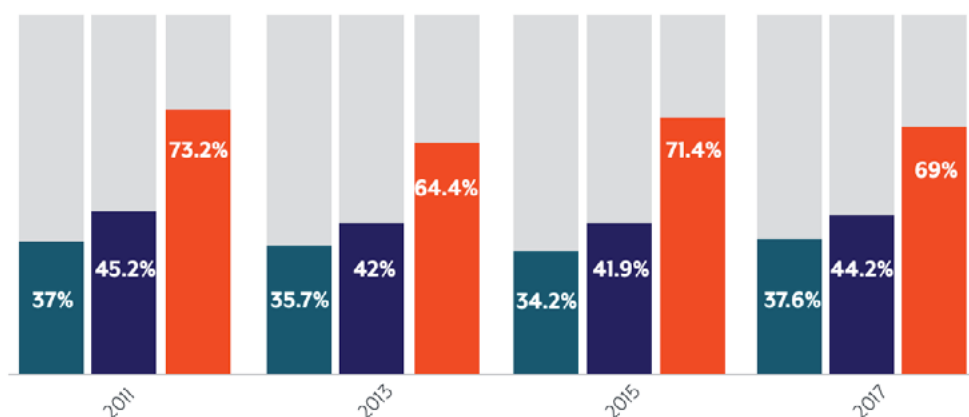


Figure 2: Graph from Movement for Family Power Report, "[Whatever They Do, I'm Her Comfort, I'm Her Protector: How the Foster System Has Become Ground Zero for the U.S. Drug War](#)", pg. 63

The NY campaign has resulted in policy changes. For example, in [September 2020](#),⁶⁰ New York City's Health and Hospitals Corp. (NYCHHC) changed their internal policies to require doctors to obtain informed consent prior to drug testing pregnant and parenting people. This shift was a direct result of the advocacy and activism of the Informed Consent Coalition. Unfortunately, these changes were not enough. The NYCHHC policy would only be implemented at the city's public hospitals and would not extend to private institutions or public hospitals outside of New York City. It also did not include newborns, which leaves healthcare providers with the ability to test infants without informed parental consent. The fight for informed consent must continue.

II. CALIFORNIA DEMAND FOR INFORMED CONSENT

In California, advocates in the [Reimagine Child Safety Coalition](#) are working in Los Angeles to ensure that medical providers obtain informed consent prior to drug testing.⁶¹ A coalition of organizations have also introduced a state bill, [AB-1094, to demand informed consent](#).⁶²



The law in California, like New York, is clear: “a positive toxicology screen at the time of the delivery of an infant is not in and of itself a sufficient basis for reporting child abuse or neglect.”⁶³ There is also no law specifically criminalizing the use of substance during pregnancy, however there are legal cases that presumptively assume that parents of children under the age of six have neglected their children when they have “abused” substances. This law uses the term “abuse” without any medical or scientific precision, and as such leaves parents who use substances vulnerable to widespread FRS criminalization.⁶⁴

With the work of activists, Black femmes and advocates the tides are turning. In 2023, [AB 2223](#), went into effect, clarifying that “a person shall not be subject to civil liability or penalty...based on their actions or omissions with respect to their pregnancy.”⁶⁵ Actions during pregnancy would include drug use, so AB 2223 should apply to prevent FRS agencies from removing children based solely on drug use during pregnancy. Although advocates are hopeful, there is still a long history of family separation in California as a result of hospital-initiated drug tests and reporting. Moreover the culture of criminalization persists, and there is a definite need for medical providers—at minimum—to be providing meaningful informed consent prior to drug testing of parents, as well as ending medically unnecessary drug tests altogether. It would be a first step to building the trust that pregnant Californians deserve.

III. MARYLAND DEMAND FOR INFORMED CONSENT

In Maryland, [Bloom Collective](#) – a collective group of perinatal and postpartum practitioners dedicated to maternal health, birth and reproductive justice, and community sustainability – in partnership with the [Office of the Public Defender](#) are also working to ensure that pregnant and parenting people are armed with the right to informed consent before being screened or tested during pregnancy or childbirth. Like New York and California, Maryland’s law also states that a positive drug test—alone—is not enough to prove child neglect under Maryland law.⁶⁶ However, the reality is that families face FRS intervention frequently because of a positive drug test. This is, in part, due to Maryland’s law that requires that healthcare providers to report any positive test or screen to the Department of Social Services (DSS). While healthcare providers are not required by any state or federal law to drug test, most, if not all, Maryland hospitals have adopted universal test and report policies.

Currently, the law requires that if a person tests positive during or after childbirth for any controlled substance, including prescribed ones, they must be reported to the local Department of Social Services for a “Substance Exposed Newborn (SEN) referral.”⁶⁷ Officially, SEN referrals include an assessment of the family’s strengths and connections to services, however in practice this is rarely the case. After the assessment is concluded parents who used drugs are referred to programs that are supposed to be “voluntary” but if a parent refuses these services an investigation ensues.⁶⁸ The Bloom Collective and the Maryland Office of the Public Defender have been working to pass informed consent legislation for two years. The legislation has failed to be voted out of committee in both [2022](#) and [2023](#), receiving opposition from the Maryland Hospital Association, Maryland Association of Obstetricians and Gynecologists, MedChi, Maryland Patient Safety, and the Maryland Department of Human Services. They are continuing their fight to decriminalize pregnancy and parenting for people who use drugs, and believe that informed consent can be a way to intervene and interrupt this web of criminalization, giving patients the time to understand the consequences of consent.



IV. NON NEGOTIABLE COMPONENTS OF INFORMED CONSENT

People impacted by FRS have combined with reproductive and birth justice advocates, lawyers, academics, and medical professionals in NYC to determine what informed consent looks like for pregnant and parenting people who use drugs. It is *imperative* that policy makers listen to these advocates who have *actually* experienced FRS either first hand or through daily advocacy interactions. Their expertise is unparalleled.

There should be no law passed around informed consent that does not at least require the following:

1. Informed Consent is permission granted by the patient with full knowledge of all possible risks and consequences.

This is consistent with [The American College of Obstetricians and Gynecologists which recommends that](#), “Before performing any test on the pregnant or neonate, including screening for the presence of illicit substances, informed consent should be obtained from the pregnant person or parent. This consent should include the medical indication for the test, information regarding the right to refusal and the possibility of associated consequences for refusal, and a discussion of the possible outcome of positive test results. In addition, obstetricians-gynecologists or other obstetric care practitioners should consider patient self-reporting as an alternative, which has been demonstrated repeatedly to be reliable in conditions where there is no motivation to lie and in clinical settings where there are no negative consequences attached to truthful reporting.”

2. Informed Consent must be obtained prior to drug testing and drug screenings.

In recent years, some medical providers have recognized the highly invasive nature of obtaining bodily fluids like urine or blood from patients and have opted to shift practices to using surveys, questionnaires or conversations to elicit information about drug use. Questions range from types of substances used to frequency, intensity, and triggers for use. There is a perception that these screenings, whether random, selective, or

universal, are less invasive than drug testing and could reduce reporting disparities. However, a recent [study](#) found that Black and white pregnant people screened positive for substance use at similar rates and Black women entered treatment programs at increased rates;⁶⁹ Black babies were still four times more likely to be reported to FRS at delivery and have [172% higher odds for being tested](#).⁷⁰ This is unsurprising and consistent with the history of racism in the US, the segregationist policies which undergird FRS and the actual intent of family separation laws. The history of Family Separation in the U.S. necessitates that informed consent be obtained regardless of the testing/screening tool. Families who use drugs are criminalized and need to understand the consequences of their consent as they work to keep their family together.

3. Informed Consent must be obtained prior to Drug Testing/ Screening Newborns AND their Parents.

Informed consent law needs to include newborns; time and time again, directly impacted people and advocates on the front line report that pediatricians, in particular, will ignore parents and just drug test children—a practice called “bagging” to refer to the process of capturing urine from a newborn by putting a bag around their genitals. If the law is not extended to newborns, likely in situations where parents refuse testing, health care providers will instead subjugate that person’s new baby to drug testing. [Black, Brown, Indigenous and Low-Income children deserve bodily autonomy and studies confirm that they are at higher risks of drug testing without clear medical need](#).⁷¹ There is no medical exception that justifies bypassing informed consent from parents in the case of newborn drug testing. Every other test and procedure requires parental consent (except in the case of emergency), such as routine “heel and prick” tests that screen newborns for congenital defects. It would be illogical not to extend this protection in the case of drug testing. Moreover, this is a valuable opportunity for a provider to talk to parents about their individual wellbeing and that of their child, provide honest and accessible information and options, and make connections to systems that provide support—as well as for providers to interrogate what actual medical purpose (if any) is being served with the drug test.

4. Informed Consent Laws Must be Rooted in Birth Justice and Reproductive Justice Principles.

Informed Consent Laws that function as “advisory” or “legal rights” are not the same as Informed Consent Laws rooted in the right to bodily autonomy and reproductive justice. Indigenous women, women of color, and trans people have always fought for Reproductive Justice—which defined by SisterSong⁷² is the “human right to maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities.” It must be clear that hospitals must be providing informed consent that is consistent with reproductive justice principles—which is rooted in the patient’s autonomy not the hospital’s interest. Moreover, it demands that informed consent be more than a legal waiver or cursory conversation but rather a meaningful process that shifts power away from the institution and into the hands of the pregnant and parenting person. Informed consent, cannot exist without bodily autonomy, meaningful choice, and the ability to refuse consent without punishment.

5. Informed Consent Laws Must Explicitly Require the Following Components:

- Right to be informed in the language of the patient’s choice
- Requirement that written permission is obtained prior to testing or screening
- A right to notification that the disclosure or test results could have legal implications (such as FRS interaction)
- A right for the patient to have the opportunity to make a voluntary decision (this means there is time to discuss options)
- A right for the patient to seek legal or outside support
- An explanation and documentation of the medical purpose of the test
- The right to refuse consent on behalf of themselves or their child in non-emergency situations, without losing access to treatment or facing other consequences as the result of refusal

B. ORGANIZING FOR LIBERATION

Informed Consent laws are an intervention into the web of criminalization, and should be adopted, however there will need to be radical changes in both hospital policy and culture to shift the criminalization of pregnant people who use drugs. Efforts like the [Beyond Do Harm Network](#)— a group of US-based health care providers, public health workers, impacted community members, advocates, and organizers working across racial, gender, reproductive, migrant and disability justice, drug policy, sex worker, and anti-HIV criminalization movements—are successfully working to address the harm caused when health providers and institutions and public health researchers and institutions facilitate, participate in and support criminalization.⁷³

This network offers 13 principles for supporting people's agency, self-determination, dignity of risk, and general wellbeing to interrupt the criminalization of patients in medical systems. Some of these efforts include: ending medically unnecessary information gathering, documentation, and surveillance; ending medically unnecessary screening and drug testing without consent, and ending mandated reporting. Moreover this network highlights the need for providers to self-organize and challenge their institutions to adopt and administer policies that will create safety for their patients.



Figure 3: Beyond Do No Harm Network is a group of US-based health care providers, public health workers, impacted community members, advocates, and organizers working across racial, gender, reproductive, migrant and disability justice, drug policy, sex worker, and anti-HIV criminalization movements to address the harm caused when health providers and institutions and public health researchers and institutions facilitate, participate in and support criminalization. Below we offer thirteen principles for supporting people's agency, self-determination, dignity of risk, and general wellbeing.

V. The Struggle Continues

While this report has sought to highlight efforts across the country, the reality is that there are numerous actions that policy makers must support if they are truly seeking to decriminalize drug use and interrupt the legacy of family separation in the U.S. Below is an outline of initiatives that legislators and policy advocates can also support to ensure that we are building a safer, and healthier world for families. We ask that legislators to learn more about these efforts, follow grassroots leaders in their states leading these charges, and build policy agendas that center these initiatives.

Additional Steps Legislators Can Take to Build Healthy FRS Policy Agendas:

1. States should refuse CAPTA funds and federal legislators should work to REPEAL CAPTA.

Follow the work of [@RepealCAPTA](#) to learn more about the fight to end this ruthless federal law.

2. Legislators should support repealing federally punitive FRS laws such as the Adoption and Safe Families Act, which places families on timelines to “fix” substance use.

Legislators should reject any reforms to ASFA that shorten timelines or “fast track” terminations for people who use drugs. Follow campaigns like www.repealasfa.org to learn more.

3. Legislators should work to end the practice of “test and report” by:

- Statutorily barring family regulation cases where parents’ drug use is the only allegation.
- Diverting funds away from FRS in to community-based harm reduction efforts.
- Encourage hospitals to end testing and screening policies and supporting efforts outlined in this brief.

4. Legislators should support measures to decriminalize drug use.⁷⁴

- Eliminate penalties for drug use and possession (of substance and equipment) and low-level drug sales.
- Decarcerate people incarcerated for drug offenses.
- Minimize coercion and harm inflicted on people who use drugs.
- Center the voices of people who have been most impacted.
- Invest in communities most harmed by the War on Drugs.
- Focus on voluntary, evidence-based interventions to improve health.
- Support decriminalization bills.

5. Legislators should invest in community-based responses for families.

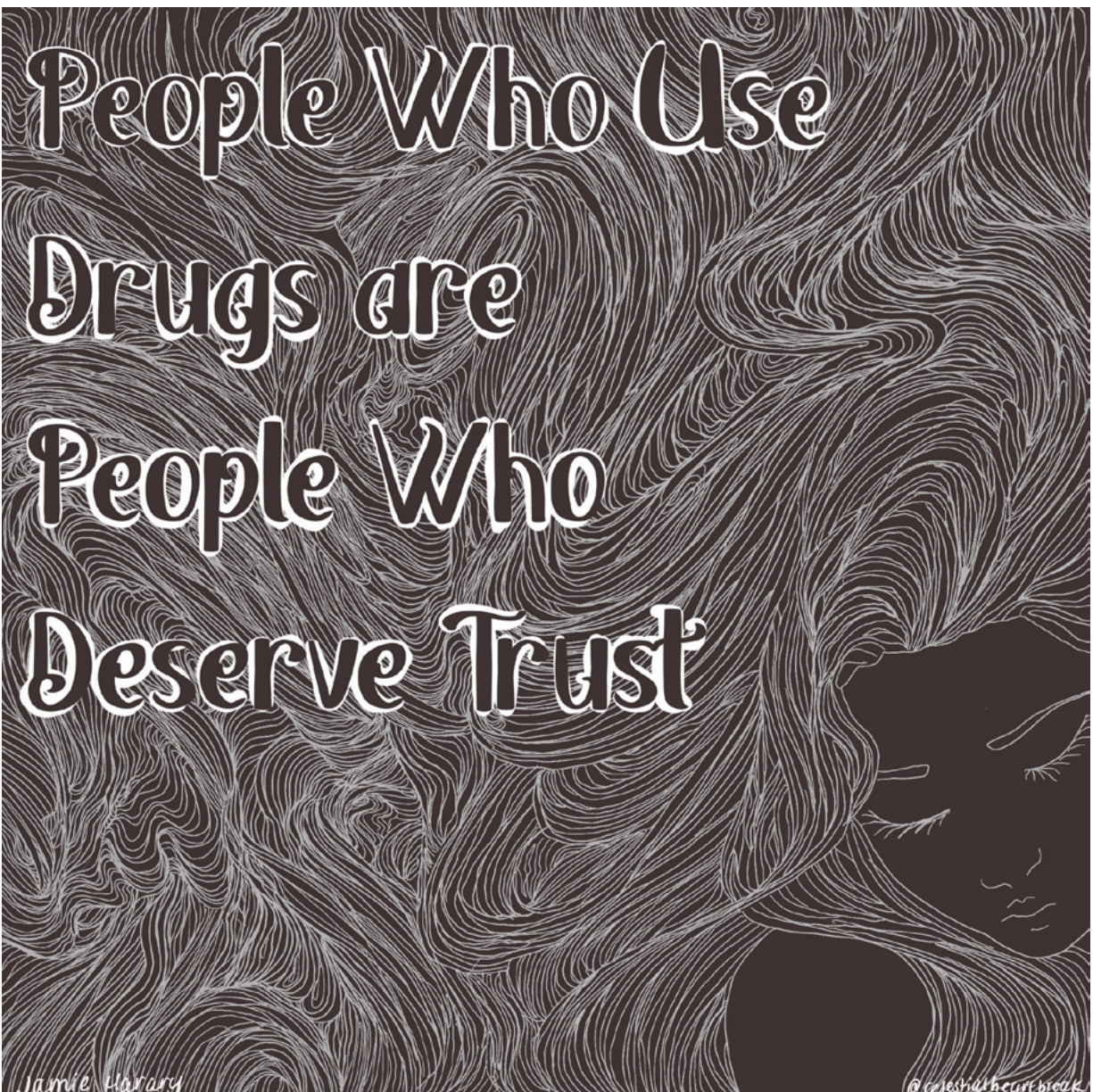
- [Studies](#) have demonstrated the importance of mutual aid and community care in the effort to empower subjugated communities.⁷⁵ These measures allow for families to build a network of support with trusted sources and avoid the intrusion of invasive surveillance. A [study](#) conducted during mutual aid efforts of the Covid-19 pandemic demonstrated that this not only had positive effects on the health of families, but did not result in a rise of child abuse that some had predicted would occur as a result of less state supervision.⁷⁶
- Policymakers must invest in community based efforts that increase parental access to childcare needs and other services, professional development, and essential supplies (food, clothing, toiletries) that are led by and for families from oppressed communities.

6. Legislators must fund doulas, midwives and eliminate barriers to professional licensing, and ensure they are not mandated reporters.

7. Legislators should support reparation efforts, especially for families who have been torn apart by FRS.

VI. Closing

Care providers and policymakers can improve the lives of families and children by extending support to parents rather than penalizing them. The family regulation system does not heal or protect but instead increases trauma and prevents growth. Drug testing and reporting to FRS, even when there is harm to a child, might be tempting, but is not effective. The time is now to end the harms of U.S. family separation policies.



Appendix I Timeline

1853-1929: Orphan Train Project

Proposed by Charles Loring Brace and directed by the Children's Aid Society, over 200,000 children were forcefully displaced from urban areas into rural communities in the mid-west and west. With the aim of "civilizing" these children, upon arrival many were required to engage in domestic and farm labor.⁷⁷

1900s-1970's: Boarding Schools /Adoption Project

Boarding schools served with a similar "civilizing mission" to that of the Orphan train projects. Indigenous youth were forcibly removed from families to attend boarding schools, often far from home, to assimilate these youth. Native languages, customs, and attire were forbidden. Youth faced abuse and even death at these boarding schools. After significant scrutiny from indigenous communities and activists, the U.S. government shifted its focuses from boarding schools to adoption. Indigenous youth were removed from their homes via family regulation systems and placed in primarily white homes, where again, forced assimilation and cultural erasure was the goal.⁷⁸

1935: Social Security Act passes

Creates public welfare for low-income children, establishing federal funding for children's social service, in particular for fostercare.⁸⁰

1960: Suitable Home Laws

Created legislative foundation for excluding communities from receiving assistance. This policy largely targeted and effectively cut off poor Black mothers and family from receiving welfare services.⁸²

1960s: Mandatory reporting policies are most directly attributed to the medical community

Intended to address physicians' frequent reluctance to report or identify child abuse injuries as such, deferring to the social norm that parenting and corporal punishment are private family affairs.⁸⁴

1880s-1940s: American Eugenics Movement

Francis Galton coined the term in 1883 and the movement gained widespread appeal and was integrated in educational and legal institutions having far reaching effects. The premise, loosely based on early conceptions of genetics, was that undesirable traits could be eliminated from the human race through selective breeding.

1912: Federal US Children's Bureau founded

Bureau later advanced mandatory reporting as a necessary policy.⁷⁹

1942-1972: Civil Rights Movement

Resulted in positive progress and de-segregation but also witnessed a backlash of anti-black child removal and family regulation policies.⁸¹

1960: Flemming Rule

Administrative loophole created by Arthur Flemming, which required states to provide assistance to children living in "not suitable" homes, which typically looked like removal of children and placing them into what the state deemed as suitable. Like the Suitable Home Laws, this led to disproportionate removal of Black, Brown, and Indigenous youth.⁸³

1961: Physician Dr. C. Henry Kempe et al. publish seminal report on child abuse, *The Battered Child Syndrome* Report's widespread recognition throughout the 1960s garners advocacy for child abuse as a social problem.⁸⁵

1962

US Children's Bureau conference puts forth model mandatory reporting state legislation focused on physicians and institutional responsibility.⁸⁶

1966: Large U.S. cities begin assigning Police in Schools

Cities like Tucson, Miami and Chicago begin assigning police in schools

1970s: Numerous states adopt Universal Mandatory Reporting Policies

These policies require that all people — regardless of profession — are mandatory reporters. Such policies have been shown to increase reporting but not of proportionally higher confirmed reports.⁸⁸

1974: The Child Abuse Prevention and Treatment Act (CAPTA)

CAPTA mandates notification to FRS of births affected by illegal and legal drugs and accounting of these notifications. Rapidly expanding since 2003, CAPTA has incentivized states to police and punish drug use during pregnancy. This action goes against the recommendation of leading medical organizations such as the American College of Obstetricians and Gynecologists. Although CAPTA is intended only to be a way for data collection around maternal substance use, to purportedly allocate resources, states have widely interpreted it to require hospitals to report all positive toxicologies for infants at birth to the family regulation system. The reporting of maternal substance use is deeply problematic. It raises reproductive justice concerns regarding the policing of pregnant people's actions and reinforces that hospitals are sites of surveillance and not treatment. While the law says that women should get a plan of safe care for substance use, the plan of safe care is interpreted widely to be a FRS intervention, which is decidedly not treatment. Low-income Black women are more likely to be subject to drug testing and reporting than white women.⁸⁹

1965: Moynihan Report is Released

Daniel Patrick Moynihan, Assistant Secretary of Labor, releases "The Negro Family: The Case for National Action. This report relies on racial tropes about Black families creating punishing narratives about Black caretakers and their children. Racist and Conservative politicians utilize this report to push racist policies and narratives.

1968: Nixon Campaign initiates the War on Drugs which continues through the Nixon Administration intentionally overstating the threat of drugs as a strategy to disrupt anti-war organizing and Black communities.⁸⁷

1971: The Comprehensive Child Development Act

which would have implemented a national day care system, passed both chambers with bipartisan support but was vetoed by President Richard Nixon.

1978: Indian Child Welfare Act (ICWA)

Implemented after the mass removal of Indigenous children and enacted after many Indigenous families demanded change, ICWA requires that all family regulation system court proceedings involving Native American children be heard in tribal courts and that tribes have the right to intervene in state court proceedings. It established guidelines for family reunification and placement of Native American children and the Indian Child Welfare grant program.⁹⁰

1980: The Adoption Assistance and Child Welfare Act (AACWA)

Passed to address concerns that children were being unnecessarily removed from their homes and inadequate efforts were being made to reunite families or find adoptive homes for children, this act formalized the family regulation system and established a federal role in administering and overseeing FRS. Specifically, it established the first federal procedural rules governing the management, permanency planning, and placement reviews. It required states to develop plans detailing the delivery of services, make “reasonable efforts” to keep families together by providing both prevention and reunification services, created an adoption assistance program, and solidified the court system’s role by requiring review of cases regularly.⁹¹

1986

President Reagan announced a goal to create drug-free workplaces, leading to the Drug Free Workplace Act which most acutely exposed low-income workers to regular drug testing despite similar rates of drug use across all classes. This increased their risk of job loss despite ability to perform job tasks and a drug test’s inability to identify if they were intoxicated while at work.

1986-1995

Around the same time as the passage of AACWA, child removals began to grow; between 1986 and 1995, children in the foster system went from approximately 280,000 and 500,000, a 76% increase. This increase coincided with the “crack epidemic” and the founding of the War on Drugs, which led to the mass incarceration of particularly Black men and boys. Less often do we discuss the increased surveillance of Black families and the persecution of Black mothers through similar involvement of family regulation agencies. Between the passage of AACWA and the next significant child welfare bill, The Adoption and Safe Families Act (ASFA), passed in 1997, a few less topic-relevant reforms passed, including the Family Preservation and Family Support Services Program and Child Welfare Waivers.⁹²

1990s

Zero tolerance policies emerged in schools beginning in the 1990’s due to a perceived but unfounded uptick in youth drug use and violence. These policies increased suspensions, expulsions, and the presence of law enforcement, metal detectors, random searches, and drug testing. Increased surveillance tactics had the greatest effect on Black, Latinx, and Indigenous students, with higher rates of suspensions, expulsions, and arrests. Interferences in education such as these lead to decreased engagement in school, which increases student’s risk of poorer employment and health outcomes in the future.

Early 1990s

1990 national rate of unsubstantiated reports increases to 60-65%.⁹³

1994: Multi-Ethnic Placement Act (MEPA), and 1996: Inter-Ethnic Placement Provisions

Prohibits family regulation system agencies that receive federal funding from delaying or denying foster or adoptive placements because of a child or prospective foster or adoptive parent's race, color, or national origin, and from using those factors as a basis for denying approval of a potential foster or adoptive parent. The law also requires agencies to recruit foster and adoptive parents that reflect children's racial and ethnic diversity in out-of-home care, a process known as diligent recruitment. The downside of this legislation is that it removed race from being a preferring factor for placements at a time when Black and Brown youth were being disproportionately removed from homes by FRS.

Further, this legislation failed to address the common 'screening out' tactics by FRS agencies that consistently leave out Black, Brown, and Indigenous Families from being able to foster or adopt youth in care. These laws have continued to promote transracial adoptions of Black and Brown children into white families.⁹⁴

1997: The Adoption and Safe Families Act (ASFA)

Made significant changes to the nation's foster system, most importantly it emphasized adoption over family reunification for children in the foster system; created a financial incentive for terminations of parental rights but not reunification; and shortened the period FRS agency had to "work" with a parent to 15 months.

Since its passage, ASFA has succeeded in reaching its own destructive goals: in the few years after ASFA took effect, the adoptions of children in the foster system increased from 28,000 in 1996 to 50,000 in 2000. In 1999 and subsequent years (2005-2014), the number of adoptions of children in the foster system continued to hover around the 50,000 mark. While the benefits of all these adoptions should be questioned, the drastic increase in terminations of parental rights is particularly troubling for Black children because terminations do not lead to the same outcomes for them as for white children. Black children in the foster system are significantly less likely than their white counterparts to be adopted once they are "freed."

These children have lost their parents (and often their siblings) without achieving the "permanency" at which ASFA was purportedly aimed. For instance, in 2010, of the foster children whose parents' rights had been terminated, approximately 53,500 children were adopted, but a staggering 109,000 children had not yet been. Only 24% of the children adopted that year were Black, while 43% of the children adopted that year were white. The current child welfare statistics for 2018 report similar trends.⁹⁶

1996

In 1996 Congress passed the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA). This allows for the drug testing of applicants and recipients of Temporary Assistance for Needy Families (TANF) as well as penalizing those who test positive. Today, 13 states drug test TANF recipients. Depending on the state, some require people with felony drug convictions to take a drug test, while others "screen" for drug use and then require it upon suspicion. In most states, a positive drug test disqualifies a person from receiving TANF benefits. Removal of benefits results in increased hunger, eviction and homelessness, utility shut-off, and inadequate healthcare. PRWORA disproportionately affects Black, Latinx, and Indigenous people, and has disastrous effects for all low- and no- income people. A positive drug test does not indicate whether an individual is a loving, caring, and capable parent, but removal from social safety systems can affect a parent's ability to be present and provide for their families.⁹⁵

2001: Ferguson v. City of Charleston

A public hospital sets up a drug testing protocol with the police. Supreme Court decides that a state hospital's performance of a diagnostic test to obtain evidence of a patient's criminal conduct for law enforcement purposes is an unreasonable search if the patient has not consented to the procedure. Supreme Court does not invalidate drug testing for purposes of reporting to child protective services.⁹⁷

Appendix II Coloring Page

The work to end drug testing is intertwined with the fight to end reporting to child protective services. Young people deserve safe adults that they can talk to, confide in and receive support from. They deserve people who support, not report.

SAFE ADULTS SUPPORT.
THEY DON'T REPORT.



ART BY: JAMIE HARARY

You have a right to a
world that helps
everyone.

#REIMAGINESUPPORT

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¹⁶ See *supra* note 12.

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²⁴ See *supra* note 17.

²⁵ Schoneich, Sebastian, Melissa Plegue, Victoria Waidley, Katharine McCabe, Justine Wu, P. Paul Chandanabhumma, Carol Shetty, Christopher J. Frank, and Lauren Oshman. "Incidence of Newborn Drug Testing and Variations by Birthing Parent Race and Ethnicity Before and After Recreational Cannabis Legalization." *JAMA Network Open* 6, no. 3 (March 8, 2023): e232058. <https://doi.org/10.1001/jamanetworkopen.2023.2058>.

²⁶ CAPTA is a federal law passed in 1974, and regularly reauthorized, which provides states FRS agencies with grant funding in exchange for state compliance with specific requirements. One of the most notable portions of CAPTA include the requirements for states to implement mandated reporting laws. CAPTA is relevant to the discussion here as the law also requires states to implement policies and procedures requiring medical providers to notify the FRS in order "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 ... "Additionally CAPTA requires states to "develop[] a plan of safe care for the infant born and identified as being affected by substance abuse or withdrawal symptoms, or a Fetal Alcohol Spectrum Disorder to ensure the safety

and well-being of such infant following release from the care of health care providers..." Child Abuse Prevention and Treatment Act, 43 U.S.C §§ 5101-5106g (2021). <https://www.congress.gov/bill/93rd-congress/senate-bill/1191>

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²⁸ Korn, Allison E. "Detoxing the Child Welfare System." *Virginia Journal of Social Policy & the Law* 23, no. 3 (2016): 293–349. https://scholarship.law.duke.edu/cgi/viewcontent.cgi?article=6869&context=faculty_scholarship.

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³⁰ See *supra* 2.

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³⁶ The American College of Obstetrician-Gynecologist. "Substance Abuse Reporting and Pregnancy: The Role of the Obstetrician-Gynecologist." The American College of Obstetrician-gynecologist, January 2011. <https://www.acog.org/en/clinical/clinical-guidance/committee-opinion/articles/2011/01/substance-abuse-reporting-and-pregnancy-the-role-of-the-obstetrician-gynecologist>.

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⁴⁰ Scott, Karen A., Laura Britton, and Monica R. McLemore. "The Ethics of Perinatal Care for Black Women: Dismantling the Structural Racism in 'Mother Blame' Narratives." *The Journal of Perinatal & Neonatal Nursing* 33, no. 2 (2019): 108–15. <https://doi.org/10.1097/JPN.0000000000000394>.

⁴¹ This paper outlines the critical role prenatal and postpartum healthcare providers can play in caring for a child and parent, as well as the health disparities, barriers to care, and systemic racism present in medical settings. While this paper focuses on health conditions outside of substance use, it highlights the need for holistic and unbiased care, especially for Black pregnant and postpartum people. Black and low-income pregnant people are at greater risk of pregnancy-related conditions, including pregestational diabetes, chronic hypertension, gestational diabetes, and preterm birth, in addition to adverse social determinants of health that affect their children's health.

Scott, Karen A., Laura Britton, and Monica R. McLemore. "The Ethics of Perinatal Care for Black Women: Dismantling the Structural Racism in 'Mother Blame' Narratives." *The Journal of Perinatal & Neonatal Nursing* 33, no. 2 (2019): 108–15. <https://doi.org/10.1097/JPN.0000000000000394>.

⁴² Social determinants of health include stress levels, exposure to air and water toxins, and access to green spaces and fresh food, all of which are also often affected by economic standing. The paper presents a role for prenatal healthcare providers to care for the pregnant person and their infant.

Scott, Karen A., Laura Britton, and Monica R. McLemore. "The Ethics of Perinatal Care for Black Women: Dismantling the Structural Racism in 'Mother Blame' Narratives." *The Journal of Perinatal & Neonatal Nursing* 33, no. 2 (2019): 108–15. <https://doi.org/10.1097/JPN.0000000000000394>.

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⁴⁴ "Separating children from their parents contradicts everything we stand for as pediatricians – protecting and promoting children's health. In fact, highly stressful experiences, like family separation, can cause irreparable harm, disrupting a child's brain architecture and affecting his or her short- and long-term health. This type of prolonged exposure to serious stress - known as toxic stress - can carry lifelong consequences for children."

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⁴⁹ This paper outlines the critical role prenatal and postpartum healthcare providers can play in caring for a child and parent, as well as the health disparities, barriers to care, and systemic racism present in medical settings. While this paper focuses on health conditions outside of substance use, it highlights the need for holistic and unbiased care, especially for Black pregnant and postpartum people. Black and low-income pregnant people are at greater risk of pregnancy-related conditions, including pregestational diabetes, chronic hypertension, gestational diabetes, and preterm birth, in addition to adverse social determinants of health that affect their children's health.

Scott, Karen A., Laura Britton, and Monica R. McLemore. "The Ethics of Perinatal Care for Black Women: Dismantling the Structural Racism in 'Mother Blame' Narratives." *The Journal of Perinatal; Neonatal Nursing* 33, no. 2 (2019): 108–15. <https://doi.org/10.1097/JPN.0000000000000394>.

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See also Cal. Penal Code § 11165.13. https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=PEN§ionNum=11165.13.

⁶⁴ A case on appeal in the California Supreme Court is currently challenging both the presumption that substance abuse by a parent of a child under six is neglect, and the determination of substance abuse without reference to medical expertise. In re N.R., Case No. S274943, Cal Supreme Court.

⁶⁵ AB 2223, Ch. 629, 2022 Cal. Stat, adding Health and Safety Code § 123467(a). <https://legiscan.com/CA/text/AB2223/id/2609184>

66 Md. Cts. & Jud. Pro. § 3-801(s). Maryland law contains a draconian one-year presumption that if a mother, upon admission to a hospital for delivery of her child, tests positive for cocaine, heroin, methamphetamine, or any derivative, including prescribed medication, and is offered but refuses drug treatment, or fails to complete the recommended level of drug treatment, that the mother is presumed to be unable to give proper care and attention to the child or the child's needs. MD CJP § 3-818. Nonetheless, in order to prove neglect, there still must be evidence that the child's health or welfare is harmed or placed at a substantial risk of harm consistent with § 3-801(s). <https://law.justia.com/codes/maryland/2018/courts-and-judicial-proceedings/title-3/subtitle-8/section-3-801/>; See also *In re William B.*, 73 Md. App. 68, 73 (Md. Ct. Spec. App. 1987) (holding that "[m]ere alcoholism of the parents is not grounds under the statute for removing a child from his home with his parents. The law permits involuntary separation of a child only if the parents are unable or unwilling to give the child ordinary care and attention, and even then only if the court finds that the drastic remedy of removing the child is necessary for his welfare.") <https://cite.case.law/md-app/73/68/>; *In re Adoption/Guardianship No. T00032005*, 786 A.2d 64 (Md. 2001) (in termination proceedings, noting earlier finding that children were CINA on the basis of mother's drug problem, which "interfered with her ability to care for the children"). Furthermore, a report of the presence of a substance "does not create a presumption that a child has been or will be abused or neglected." MD. Fam. L. Art. § 5-704.2(i). <https://casetext.com/case/in-re-adoptionguardianship-1>

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