



Violence Against Women in the Medical Setting: An Examination of The U.S. Foster System

May 31, 2019

I. Introduction

Movement for Family Power, National Advocates for Pregnant Women and the undersigned are writing in response to the call by the United Nations Special Rapporteur on Violence against Women, Ms. Dubravka Šimonović, for information on mistreatment and violence against women during reproductive health care and facility-based childbirth.

We are non-governmental organizations, activists, public defense offices, academics, and others who work every day to advance the human rights of pregnant and parenting people. We advocate for parents, mostly poor mothers and Black, Latinx and Indigenous mothers,¹ defending themselves against allegations that they have abused or neglected their children. Several signatories have been personally affected by the abuses discussed herein. We write to inform Rapporteur Ms. Šimonović of how the child protection and foster system (hereafter referred to as the “foster system”), in alliance with medical care providers, mistreats and inflicts violence on women seeking reproductive health care services in the United States.

As we share in detail below, the foster system in the United States, with the aid of medical care providers, targets poor women and women of color who are pregnant or have recently given birth for child maltreatment investigations, intensive state surveillance and control, and forced family separation, *all of which are forms of violence*. Medical care providers, especially those that provide medical care to patients who utilize public insurance, are critical to feeding families into the foster system. They work in collaboration with the state in violation of their patients’ rights by collecting confidential medical and personal information on their patients without first obtaining specific, informed consent. They also violate patient confidentiality by providing confidential medical information to child protective services, thereby triggering state intervention, and they even aid the state in apprehending newborns and severing the mother/child bond. This all occurs shortly after birth without any evidence that the mother has maltreated or

risks maltreating her newborn. Rather, stigma and discrimination attached to the pregnant woman or new mother's social marginalization, such as being poor, a racial minority, a substance user or having a disability, serves as the basis of state intervention and control.

The Special Rapporteur's mandate has been known to express concern in the past over violence against women within the context of reproductive health policy, including human rights violations resulting from direct state action and those resulting from the state's failure to meet its minimum core obligations.² The foster system's practice, in conjunction with medical providers, of collecting evidence against and prosecuting marginalized mothers, and subjecting them to temporary and permanent family dissolution, under the guise of providing reproductive healthcare, directly diminishes their dignity and right to self-determination leading to devastating consequences for themselves and their families. In the report, *Criminalizing Pregnancy: Policing Pregnant Women Who Use Drugs in the USA*, Amnesty International described a "patchwork of laws" used to punish poor, and often Black, Latinx and Indigenous, pregnant people and violate their human rights.³

a. Human Rights Implicated

Numerous human rights declarations recognize the right to retain care and custody of one's children as one of the most fundamental human rights.⁴ This right is further enshrined in treaties that protect marginalized classes of people, such as people with disabilities and Indigenous peoples, whose reproduction and parenting has come under attack as a way of literally diminishing these populations.⁵ People in the United States who seek reproductive healthcare experience mistreatment and violence at the hands of medical care providers and the foster system, based on suspicion that they are unfit parents, a suspicion that arises due to their race, socio-economic status, and stigma associated with their other marginalization, such as status as a substance user. Their rights to legal counsel; medical privacy and bodily integrity;⁶ health;⁷ freedom from arbitrary detention;⁸ privacy in family life;⁹ not to mention the most fundamental right to parent¹⁰ are all routinely violated. This is coupled by inadequate accountability mechanisms that would ensure redress for victims of mistreatment and violence at health facilities or following harmful actions by health providers. As will be explored later in this submission, methods of redress or accountability for these harms are few and far between.

This failure by the United States to uphold its rights and obligations stands in contravention to treaties it has ratified, as well as customary international norms. While the U.S. has not ratified the key treaties pursuant to the lives of impacted populations described herein (i.e. the International Covenant of Economic and Social Rights, the Convention on the Rights of the Child, or Convention on the Elimination of all forms of Discrimination against Women), it is nonetheless obligated to ensure that government functions to protect the dignity and rights of the people, and that they are free from discrimination (implicated in the treaties it has ratified, including the International Covenant on Civil and Political Rights, Committee on the Elimination

of Racial Discrimination, etc.). Moreover, given the recent reports of the Special Rapporteurs who have completed missions examining critical issues in the U.S., inadequate social infrastructure or systemic protections ensure future rights violations.¹¹ As such, it is crucial for the Special Rapporteur to examine the actions discussed herein of the foster system in conjunction with medical providers.

II. Overview of U.S. Foster System

The foster system in the United States is a civil legal system, composed of child protective service agencies, foster care and adoption agencies and family courts. There is no federal legal definition of “child maltreatment” in the United States, but there are minimum federal requirements states must meet in this area to receive federal funding.¹² Every U.S. state has a distinct agency mandated to receive and investigate allegations against parents for suspected child neglect and abuse. The system includes state laws, policies and practices broadly defining child neglect/abuse and who must report suspected neglect or abuse (including medical providers) to the relevant agency, violating the right to medical privacy. The family courts are empowered to issue orders against parents to comply with a variety of programs and services, remove children from their care, and even permanently sever the parent child relationship.¹³ Parents in the system are overwhelmingly poor,¹⁴ and Black¹⁵ and Indigenous¹⁶ parents are vastly overrepresented.

Several scholars have undertaken painstaking review of the data, literature and historical record to make the case that the foster system is a racist, classist and sexist institution. In her seminal book *Shattered Bonds*, one of America’s leading scholars on race, gender and the law, Dorothy Roberts, writes that the Foster System “systematically demolish Black families.”¹⁷ In one of the foremost historical accounts of the development of the foster system, renowned scholar Leroy Pelton explained how the Foster System was developed in place of anti-poverty programs for the country’s neediest children and families.¹⁸ Leroy Pelton wrote “If we cannot defend the societal neglect of innocent children, let us separate them in a manner that they can be treated differently than their mothers.”¹⁹

As people and organizations who advocate for the rights and dignity of parents and families, these facts are abundantly clear to us. Foster system “interventions” made under the guise of “protecting children from their parents” are in fact rooted in a racist, colonial, and classist ideology that view poor parents and Black, Latinx and Indigenous parents as less fit to parent and more in need of government supervision to care for their children.

Therefore, the “interventions” that stem from this ideology have resulted in incredible harm to pregnant and parenting people and their children. It has been much easier for the United States to blame mothers for the profound effects of unaddressed, intergenerational, structural racism,

poverty, and ongoing colonialism on their children than to admit to these massive policy failures or to proactively create strong protections and systems that center the dignity of poor mothers and their families.²⁰ To put it succinctly, the foster system is born of a larger societal context that devalues the motherhood of poor people and people of color. This has rightly been recognized by the special rapporteur’s peers. In his last report upon a mission to the U.S., the Special Rapporteur on Extreme Poverty and Human Rights noted the U.S.’s failure to recognize economic and social rights, and instead to rely on punishment and “criminalization to conceal the underlying poverty problem.”²¹

a. Child Removals as the Default Government Intervention

The foster system’s primary response to alleged child maltreatment is to remove the child from the parent’s care and place them into the foster system. The foster system spends almost three times as much money on removing children from their families’ care and placing them in the foster system than on putting services in place to keep families together.²² These financial incentives have real life implications. Rather than funding assistance for poor families or supporting them in times of need, the foster system uses poverty as grounds to separate them. For example, several studies show that over one third of the children in the foster system could return to their parent’s care if their parents just had adequate access to housing.²³

This is not to deny the instances, as rare and isolated as they are, of severe harm that children experience at the hands of their parents and caregivers. Rather, this is to say that the foster system as it exists today, was not designed to prevent, address or heal that harm.

b. The Impacts of Family Separation are Devastating

Removing a child from the care of their parents, particularly a newborn, is one of the most violent actions a government can take against its people, with profound implications.²⁴

These separations rupture the bond of a child to their primary attachment figure, disrupting brain architecture and triggering a proliferation of toxic stress, which evidence suggests can have acute and long-term adverse health effects.²⁵ Studies and life experience show that this is just as

“Taking children away from their mothers is harmful to them, there’s nothing complicated about that, and there’s incredibly strong science and a big hunk of common sense that both lead us to the same conclusions.”

- Jack Shonkoff, Director of the Harvard University Center for the Developing Child.

much true for children who face zero risk of parental maltreatment as it is for children who face risk of parental maltreatment or have been maltreated.²⁶

Following separation from newborns, mothers, in particular, experience a host of negative health and social consequences. Immediate and far reaching harms include severe mental health distress, (e.g suicidality, depression, anxiety, post-traumatic stress, postpartum depression), substance use, and premature mortality.²⁷ Alongside these health outcomes, research also points to heightened social disadvantages, including women's loss of housing, employment, income and social support, and increased stigma.²⁸ Notably, these outcomes also compound societal disadvantages *already* faced by these women prior to removal of their children, further escalating systemic disregard and health/social inequities for mothers and creating significant barriers to rebuilding their lives and families.

III. The Entanglement of Medical Care Facilities and Foster Systems

Many children and parents come to the attention of the foster system as newborns or infants, as the result of an expecting mother seeking prenatal care or giving birth in a medical care facility,²⁹ particularly for mothers on public health insurance (i.e. Medicaid). This is due to a deeply troubling alliance between medical personnel who provide medical care to women and the foster system.

Medical providers are critical to feeding women and newborns into these systems through the following actions: routinely collecting evidence and private information from their unwitting patients without seeking specific and informed consent³⁰ — including testing patients suspected of using controlled substances³¹ and their patients' newborns without their informed consent³² — breaking patient confidentiality and ethical and legal obligations they owe their patients³³ by turning over this information to child protective services, and then assisting child protective services in seizing the patient's child from the new mother and prosecuting the mother for child maltreatment. Medical providers can even go so far as to prevent the mother and newborn from leaving the medical facility or from breastfeeding despite having questionable to no legal authority to do so.³⁴

Common examples of targeting and discrimination by medical personnel include (but are not limited to) calling child protective services when the mother is suspected of using substances while pregnant;³⁵ when the patient contests or refuses to consent to a medical procedure during childbirth;³⁶ when the patient reveals that they are experiencing prenatal or postpartum depression;³⁷ when the patient herself is in foster care;³⁸ when the patient has a child who has prior foster system involvement;³⁹ when the patient is incarcerated;⁴⁰ or when the patient has a disability.⁴¹ All of these factors make it more likely that a mother will have her newborn taken from her at birth.

Notably, medical facilities play an enormous role in feeding women into the system, often despite an absence of explicit requirements to report these women to the foster system and despite the absence of a demonstrable risk of harm or actual harm. The precipitating event for these calls are the medical condition (e.g. substance use disorder) or circumstance (e.g. patient's prior child has foster system involvement) the medical facility is presented with. More often than not there is no legal obligation⁴² on the medical care provider to report the expecting/new mother to the child abuse and neglect hotlines. Rather, medical providers exercise enormous discretion,⁴³ and stigma, stereotypes, racism and classism substitute objective judgements about whether a newborn is at risk of harm. And when there is a legal obligation, we have seen little evidence that medical providers engage in harm reduction strategies, such as: obtaining informed consent from patients before fishing for evidence against them; warning the patient of the impending report to the foster system and its consequences; or protesting the prosecution of their patients and the apprehension of newborns. Medical systems take these actions in contravention of their ethical and legal obligations to patients; with knowledge of the harms the foster system will inflict on their patients; and with knowledge that such actions are well-documented to deter women from seeking prenatal and postpartum care⁴⁴ — thereby isolating even more mothers at crucial times in their lives.

Patients whose rights are violated by their medical care providers have little recourse. Family court proceedings do not contain evidentiary safeguards against obtaining evidence in such a manner against respondent parents, such as excluding it from family court proceedings. In most states, medical consent laws in this area are vague and do not explicitly prohibit medical providers from these actions or provide a clear pathway to redress for patients. Further, some state laws explicitly require certain disclosures from medical professionals about their patients. While professional medical associations have taken clear ethical stances against these actions, they too have not provided a path to redress for patients.

Below we provide more detail on three of the most common situations in which pregnant and birthing people experience the violations discussed above: when they are suspected of using drugs while pregnant, when they are contesting or refusing medical interventions, and when they experience prenatal or postpartum depression.

a. Pregnancy and Drug Use

Since the 1970s and continuing through today, there has been a dramatic explosion of laws and policies concerning drug use and pregnancy.⁴⁵ The medical profession in the United States began drug testing and reporting poor women and Black, Latinx and Indigenous women without consent during the 1980s and 1990s, as part of a suite of drug war era policies.⁴⁶ A coalition of activists, medical and legal professionals, and others advocates for families have successfully

refuted the hysterical pitch of that era and debunked the scientific myths, such as the “crack baby,” ushered through that time. However, the ramifications of those practices, such as the policing of pregnancy and motherhood and punishing of mothers for using drugs, particularly for Black, Latinx and Indigenous mothers, are unabated today.⁴⁷

Disturbingly, the U.S. continues to deploy punitive policies conflating drug use and pregnancy with allegations of child abuse or neglect.

As we have outlined previously, the Foster System intervenes quickly and aggressively, subjecting the family to intensive supervision, family separation, and sometimes permanent family dissolution.⁴⁸ Poor women, and Black, Latinx and Indigenous women predominantly experience this type of state control. Despite similar rates of drug use between people of different races and income levels,⁴⁹ medical professionals⁵⁰ and the foster system⁵¹ overwhelmingly target poor women and racialized women for pre and post-natal drug testing and reporting to child protective services as potential child abusers.

One particularly egregious example of this is the state of Wisconsin’s Unborn Child Protection Act,⁵² also known as the “cocaine mom” law, in which the Juvenile Court subjects pregnant persons to forced medical treatment and detention in the name of protecting the unborn from exposure to controlled substances.⁵³

In 2014, in the process of applying for state subsidized health insurance, Tamara Loertscher was drug-tested and reported to government authorities, pursuant to this law, before she was even certain that she was pregnant. She was not entitled to an appointed attorney at initial proceedings, even though one was immediately appointed to represent her fetus. Following the report, the Juvenile Court ordered her into inpatient treatment and she was later put in jail when she refused the unnecessary treatment. While in jail, she received no prenatal care and was put in solitary confinement.

The UN Working Group on Arbitrary Detention concluded these proceedings to be a “form of deprivation of liberty” that is “gendered and discriminatory in its reach and application, as pregnancy, combined with the presumption of drug or other substance abuse, is the determining factor for involuntary treatment.”⁵⁴

Moreover, leading medical organizations agree that a positive drug test should not be construed as child abuse and neglect.⁵⁵ Rather, threatening a pregnant person using drugs with punitive actions — such as child apprehension as the result of seeking medical care — is quite harmful. Such threats deter pregnant people from seeking health care,⁵⁶ which can be more dangerous to the health and wellbeing of a newborn than drug use. Moreover, research is beginning to document that states with these punitive policies in place see worse outcomes in the health of babies and mothers.⁵⁷ Additionally, decades of research now show that the harms of in utero drug exposure have been greatly exaggerated, and that other environmental factors, such as poverty, access to quality healthcare, environmental toxins are *more* influential as factors for a

child's development.⁵⁸ Lastly, a growing body of research is confirming that illicit drug use is not incompatible with good, or even excellent, parenting.⁵⁹

b. Coerced Medical Interventions

It is well-documented that medical providers have coerced pregnant people to submit to medical procedures, under the threat of a call to child protective services.⁶⁰ What's more, refusing medical procedures does not constitute child abuse or neglect — and without legal authority, child protective services have attempted to remove newborn children or existing children from women's care.⁶¹ Despite explicit guidelines from the American College of Obstetricians and Gynecologists (ACOG), that advise against forcing compliance with medical procedures during pregnancy and childbirth,⁶² low income women, women of color, and women who have trauma histories (who are then further traumatized by submitting to unconsented medical procedures), bear the brunt of this mistreatment. The authors of this submission refer the Special Rapporteur to the *If/When/How Lawyering for Reproductive Justice et al.*, May 17, 2019 submission for more information and recommendations.

c. Punishing Prenatal or Postpartum Depression

The targeting of people experiencing prenatal or postpartum depression who seek care in medical facilities, is another component of how the medical and foster systems are harming instead of helping people.⁶³ As a result, pregnant people and those who have given birth are scared to seek help. In particular, women of color and low income women are disproportionately affected by postpartum depression,⁶⁴ which is not surprising as a lack of societal supports can be a contributing factor to the onset of postpartum.⁶⁵ However, this population is also more likely to be reported to the foster system in comparison to the general population.⁶⁶ Moreover, once medical providers call child protection services, subsequent state interventions can actually exacerbate symptoms of depression, that is, postpartum depression can be caused or exacerbated by losing custody of one's child.⁶⁷

All medical care, including treatment for depression, should be confidential and provided without judgment and unnecessary interventions. This is also reflective of strides achieved in the medical field to provide nuanced care and reach mothers where they are. While prevailing guidelines by professional pediatric associations articulate that child protective services should only be contacted when a child is in danger,⁶⁸ our experience is that medical providers still contact child protective services even when there is no articulable danger to a child. People in need deserve a dashboard of care and services. Patients should be able to trust their medical providers and seek assistance when experiencing prenatal or postpartum depression, instead of facing various forms of punishment. The discrepancy between policy and practice necessitates the U.S. to legislate protections for patients seeking care.

IV. Recommendations

The U.S. must amend or repeal any laws that permit punitive responses to seeking reproductive healthcare, and instead support a confidential, robust, compassionate, non-coercive, evidence-based health care response for patient needs. Accordingly:

- a. *The federal government* should amend the Child Abuse Prevention and Treatment Act (CAPTA) and all associated guidance documents that require or encourage state policies for healthcare providers to breach medical confidentiality and report patients to government authorities.
- b. *State foster systems* must eliminate the practice of prosecuting parents for allegations related to pregnancy and childbirth. For example: maternal drug use, disability, and postpartum depression, should not be treated as forms of child neglect or abuse. This includes an explicit end to all laws, regulations and policies which define child maltreatment as a parent's drug use during pregnancy.
- c. *Federal and state laws must* require medical providers to meet their professional obligations and responsibility to protect and uphold the human rights of their patients.
- d. *Medical care providers and medical organizations at the local, state and national level, who are being enlisted as state actors,* should publicly and unequivocally oppose punitive actions taken against their patients who seek reproductive health care. The U.S. must also ensure federal and state laws require medical providers to meet their professional obligations and responsibility to protect and uphold the human rights of their patients. They should practice true harm reduction tactics and reject state attempts to enlist them as agents of state surveillance and prosecution. Medical care providers who contravene their ethical obligations above and beyond what the law requires should be appropriately sanctioned.
- e. The U.S. must ensure *federal and state laws* protect patients' rights to full and informed consent for all tests and procedures conducted at healthcare facilities, including being informed of the potential negative legal consequences of seeking healthcare, consenting to tests, and revealing personal information, and create a cause of action for patients whose rights have been violated.
- f. *The federal government* should ratify and abide by the International Covenant of Economic and Social Rights and the Convention on the Elimination of all forms of Discrimination against Women.

V. Conclusion

The undersigned organizations thank the Special Rapporteur for this opportunity to share information regarding the mistreatment of mothers and newborns in medical facilities. We hope the Rapporteur can provide compelling recommendations to the U.S. government, its local agencies, and medical systems that have been enlisted as state actors, so that they can meet their human rights obligations and uphold prevailing international standards. We are available to provide further information as needed.

VI. Signatories

Organizations

- Movement for Family Power
- Center for Constitutional Rights
- National Advocates for Pregnant Women
- Bronx Defenders
- Brooklyn Defender Services
- Center for Family Representation
- Neighborhood Defender Services of Harlem
- If/When/How Lawyering for Reproductive Justice
- Reproductive Justice Clinic at NYU School of Law
- Women against Mass Incarceration
- Drug Policy Alliance
- Academy of Perinatal Harm Reduction

*Individuals**

- Professor Dorothy Roberts, George A. Weiss University Professor of Law and Sociology and the Raymond Pace and Sadie Tanner Mossell Alexander Professor of Civil Rights, University of Pennsylvania Law School
- Joyce McMillan, JMac4Families
- Elizabeth Brico, journalist
- Dr. Mishka Terplan, Professor of Obstetrics and Gynecology, Virginia Commonwealth University
- Kathleen Creamer, Managing Attorney, Family Advocacy Unit, Community Legal Services of Philadelphia
- Lauren E. Bartlett, Associate Professor of Law at Ohio Northern University College of Law
- Joelle Puccio, BSN, RN
- Glyceria Tsinas
- Erika Goyer, BA

* Individuals have signed on in their personal capacity, institutional affiliations are listed for identification purposes only.

¹ The authors' choice to write about the experiences of women is responding to the Rapporteur's mandate in addressing violations perpetrated against women seeking reproductive healthcare. Nonetheless the authors recognize that these violations are perpetrated against all people with the capacity for pregnancy, across the gender spectrum, and that in fact people outside the gender binary are all that much more vulnerable to the types of state intervention and control discussed herein.

² Report of the UN Special Rapporteur on violence against women, its causes and consequences, Ms. Radhika Coomaraswamy, in accordance with Commission on Human Rights resolution 1997/44 (21 January 1999) ("policies that deny women their dignity and right to self-determination by diminishing their capacity to make reproductive choices according to their own wishes and life circumstances . . . can lead to devastating health consequences – in many cases, compromising a woman's right to life and security of person.")

³ Amnesty International, *Criminalising Pregnancy: Policing Pregnant Women Who use Drugs in the USA*, 2017, available at <https://www.amnesty.org/download/Documents/AMR5162032017ENGLISH.pdf>. For example, families living in poverty are more likely to receive subsidies for health insurance and / or receive medical care from state-funded facilities. However, access to these valuable services comes with a price: families are more likely to be drug tested without their informed consent, and to have private medical information turned over to the government in the name of child protection. See National Council on Disability, *The Child Welfare System: Removal, Reunification, and Termination* (2012), at FN 275, available at <http://www.ncd.gov/publications/2012/Sep272012/Ch5#end>. Healthcare facilities in the U.S. routinely share patients' test results with governmental authorities under the mistaken belief that federal and state law requires the drug testing as well as the disclosure of results. See National Advocates for Pregnant Women, *Understanding CAPTA and State Obligations* (Sept. 2018),

http://advocatesforpregnantwomen.org/CAPTA%20requirements%20for%20states_NAPW.pdf. Improper drug testing and disclosure of results is just one example of patients' rights being violated. These policies cause scores of pregnant and parenting people to be mistreated by healthcare facilities and then subjected to further violence at the hands of civil, criminal, and correctional authorities. See eg Nina Martin, *Take a Valium, Lose Your Kid, Go to Jail*, ProPublica (Sept. 2015), <https://www.propublica.org/article/when-the-womb-is-a-crime-scene>.

⁴ See Universal Declaration of Human Rights, Preamble, Articles 12, 16.

⁵ See UN Declaration on the Rights of Indigenous Peoples.

⁶ "Bodily autonomy and personal integrity, including informed consent for medical treatment, are protected under multiple provisions of human rights treaties, including the right to privacy, the right to health, and the right to be free from torture and cruel, inhuman and degrading treatment ("CIDT"). In particular, the right to privacy and the right to be free from torture and CIDT are protected by Articles 7 and 17(1) of the ICCPR and Article 16 of CAT." Kaufman and Soohoo, *The Detention and Forced Medical Treatment of Pregnant Women: A Human Rights Perspective*, American Constitution Society for Law and Policy Issue Brief (March 2018).

⁷ ICESCR art. 12; CEDAW art. (U.S. has signed but not yet ratified both treaties).

⁸ Report of the Working Group on Arbitrary Detention on its visit to the United States of America, U.N. Doc. A/HRC/36/37/Add.2 (July 17, 2017).

⁹ Article 17, ICCPR.

¹⁰ Article 18, ICCPR.

¹¹ Alston, Philip, *Report of the Special Rapporteur on Extreme Poverty and Human Rights on his mission to the United States of America*, A/HRC/38/33/Add.1, ¶¶ 4-17, 71-73 (May 2018), available at <https://digitallibrary.un.org/record/1629536>.

¹² See ASFA 42 U.S.C.A. § 674 and CAPTA 42 U.S.C.A. § 5101; see also U.S. Dept. of Health and Human Services, *Child Welfare Information Gateway, Parental Drug Use as Child Abuse* (2016).

¹³ Marty Guggenheim, *What's Wrong with Children's Rights* 175 (2007).

¹⁴ *Id.*

¹⁵ Children's Bureau Adoption and Foster Care Analysis and Reporting System (2017)

¹⁶ *Id.*

¹⁷ Dorothy Roberts, *Shattered Bonds: The Color of Child Welfare*, January 7, 2003.

¹⁸ Leroy H. Pelton, *For Reasons of Poverty: A Critical Analysis of the Public Child Welfare System in the United States*, 1989

¹⁹ Leroy H. Pelton, *Welfare Discrimination and Child Welfare*, 60 Ohio St. L.J. 1479 1999, available at https://www.academia.edu/20235646/Welfare_Discrimination_and_Child_Welfare

²⁰ UN Special Rapporteur Alston discussed the relationship between the child welfare system and poverty in his report on the United States. See Alston, Philip, *Report of the Special Rapporteur on Extreme Poverty and Human Rights on his mission to the United States of America*, ¶¶ 4-17, 71-73 (May 2018), available at <https://digitallibrary.un.org/record/1629536>.

²¹ *Id.* at 43-46.

²² Over 60% of its roughly \$30 billion a year budget on removing and maintaining children outside the home away from their parents, compared to less than 25% of the overall budget aimed at keeping children in their parent's care. See Child Trends, *Child Welfare Financing SFY 2014: A Survey of Federal, State, and Local Expenditures* (2016)

²³ Lisa DeMatteis-Lepore and Ruth White, *Supportive Housing: An Effective Child Welfare Intervention* (2017). See generally, Center for Advanced Studies in Child Welfare, *CW360, The Impact of Housing and Homelessness on Child Well-Being* (2017). The small pool of money that is expended on services is divided between services families genuinely need, such as housing and child care, and services that function as paternalistic socialization tools, such as parenting classes.

²⁴ Laura Santhanam, *How the Toxic Stress of Family Separation Can Harm a Child*, PBS, June 28, 2018, available at <https://www.pbs.org/newshour/health/how-the-toxic-stress-of-family-separation-can-harm-a-child>. See also Kristin Turney, Christopher Wildeman, *Mental and Physical Health of Children in Foster Care*, *Pediatrics*, Volume 138, Issue 5 (Nov. 2016), available at <https://pediatrics.aappublications.org/content/138/5/e20161118> (showing association between increased mental health issues and child placement in the foster system); Joseph J. Doyle, *Causal effects of foster care: An instrumental-variables approach*, 35:7 *Children Youth Services Review* 1143 (2013), available at <https://www.sciencedirect.com/science/article/pii/S0190740911000983?via%3Dihub> (suggests placement in foster care increases the likelihood of emergency health episodes); Doyle, Joseph, J Jr. *Child Protection and Child Outcomes: Measuring the Effects of Foster Care*, *American Economic Review*, 97 (5): 1583-1610 (2007) (showing that children on the margin of placement fare better when left at home than placed in foster system).

²⁵ Shonkoff JP, Garner AS, et al., *The Lifelong Effects of Early Childhood Adversity and Toxic Stress*. *Pediatrics*, Volume 129, Issue 1 (January 2012).

²⁶ Doyle, Joseph, J Jr., *Child Protection and Child Outcomes: Measuring the Effects of Foster Care*, *American Economic Review*, 97 (5): 1583-1610 (2007) (showing that children on the margin of placement fare better when left at home than placed in foster system)

²⁷ Kenny KS, Barrington C, Green SL, "I felt for a long time like everything beautiful in me had been taken out": *Women's Suffering, Remembering, and Survival Following the Loss of Child Custody*, *Int J Drug Policy*, 2015, 26(11):1158-66. Nixon KL, Radtke HL, Tutty LM, "Every day it takes a piece of you away": *Experiences of Grief and Loss Among Abused Mothers Involved with Child Protective Services*, *J Public Child Welf*, 2013, 7(2):172-93. Wall-Wieler E, Roos LL, Bolton J, Brownell M, Nickel NC, Chateau D, *Maternal Health and Social Outcomes after Having a Child Taken into Care: Population-Based Longitudinal Cohort Study Using Linkable Administrative Data*, *J Epidemiol Community Heal*, 2017, 71(12):1145-51. Wall-Wieler E, Roos LL, Brownell M, Nickel N, Chateau D, Singal D, *Suicide Attempts and Completions among Mothers Whose Children Were Taken into Care by Child Protection Services: A Cohort Study Using Linkable Administrative Data*, *Can J Psychiatry*, 2018, Mar;63(3):170-177. Haight WL, Black JE, Mangelsdorf S, Giorgio G, Tata L, Schoppe SJ, et al., *Making Visits Better: The Perspectives of Parents, Foster Parents, and Child Welfare Workers*, *Child Welfare*, 2002, 81(2):173-202. Wall-Wieler E, Roos LL, Nickel NC, Chateau D, Brownell M, *Mortality Among Mothers Whose Children Were Taken into Care by Child Protection Services: A Discordant Sibling Analysis*, *Am J Epidemiol*, 2018, Jun 1;187(6):1182-1188. Wall-Wieler, E., Roos, L. L., Brownell, M., Nickel, N. C., Chateau, D., & Nixon, K., *Postpartum Depression and Anxiety Among Mothers Whose Child was Placed in Care of Child Protection Services at Birth: A Retrospective Cohort Study Using Linkable Administrative Data*, *Maternal and Child Health Journal*, (2018) 22(10), 1393-1399.

²⁸ Hook JL, Romich JL, Lee JS, Marcenko MO, Kang JY. *Trajectories of Economic Disconnection among Families in the Child Welfare System*, *Soc Probl* 63(2), 2016.

²⁹ Children in their first year of life have the highest rate of being adjudicated as abused/neglected more than double the rate of children in any other age group. While medical personnel are responsible for only 9.6% of all reports of abuse and neglect, for children under one in which there is an allegation of parental drug use, they are responsible for 50% of reports. Children's Bureau, *Child Maltreatment* (2017).

³⁰ As the Special Rapporteur on poverty noted in his report following an official visit to the U.S. in 2017, "[p]oor pregnant women who seek Medicaid prenatal care are subjected to interrogations of a highly sensitive and personal nature, effectively surrendering their privacy rights." See Alston, Philip, *Report of the Special Rapporteur on*

Extreme Poverty and Human Rights on his mission to the United States of America at 56. Moreover, Bronx Defenders, Brooklyn Defenders, and Neighborhood Defender Services of Harlem (all signatories of this submission), recently testified at a New York City Council Hearing that in their many years of representing parents in child abuse and neglect cases, they have never in discovery requests seen evidence of hospitals obtaining or even attempting to obtain specific informed consent before drug testing their patients. New York City Council Hearing, Committee on General Welfare and Hospitals, April 10, 2019, available at <https://councilnyc.viebit.com/player.php?hash=biao9dgYm1vx>.

³¹ We also raise that the drug tests administered are not reliable enough to be used for forensic purposes. Moreover, it is not uncommon for people who are in fact not using drugs to test positive. See Maggie Downs, *I Went to the Hospital to Give Birth...And Tested Positive for Meth*, Narratively, May 17, 2016, available at <https://narratively.com/i-went-to-the-hospital-to-give-birth-and-tested-positive-for-meth/>. See also NAPW, *Clinical Drug Testing of Pregnant Women and Newborns* (Mar. 2019), available at <http://advocatesforpregnantwomen.org/NAPW%20%2522Clinical%20Drug%20Testing%20of%20Pregnant%20Women%20and%20Newborns%2522%20March%202019.pdf>.

³² See e.g. New York City Council Hearing, Committee on General Welfare and Hospitals, April 10, 2019, available at <https://councilnyc.viebit.com/player.php?hash=biao9dgYm1vx>. See also Alison E Korn, *Detoxing the Child Welfare System* 23 Va. J. Soc. Pol'y & L. 293 (2016).

³³ Laura Beth Cohen, *Informing Consent: Medical Malpractice and the Criminalization of Pregnancy* Mich Law Rev. 2018;116(7):1297-316, available at <https://www.ncbi.nlm.nih.gov/pubmed/29999256#>. The legality of drug testing pregnant people and turning over the information to child protective services is arguably a violation of various constitutional rights and medical privacy rights, but no law definitely defines it and no case has definitely explored it.

³⁴ Open Society Foundations, Project Prevention, Child Welfare, and Junk Science, *Public Event Recording*, November 19, 2013, available at <https://www.opensocietyfoundations.org/events/project-prevention-child-welfare-and-junk-science>; Amnesty International, *Criminalising Pregnancy*.

³⁵ Discussed in detail below in section titled “Pregnancy and Drug Use”

³⁶ Discussed below in section titled “Coerced Interventions”

³⁷ Discussed below in section titled “Punishing Prenatal or Postpartum Depression”

³⁸ Elizabeth Wall-Wieler, Marni Brownell, Deepa Singal, Nathan Nickel, Leslie L. Roos, *The Cycle of Child Protection Services Involvement: A Cohort Study of Adolescent Mothers*, Pediatrics Jun 2018, 141 (6).

³⁹ Emma Ketteringham, Sarah Cremer, Caitlin Becker, Healthy Mothers, *Healthy Babies: A Reproductive Justice Response to the “Womb-to-Foster-Care Pipeline”*, 20 City Univ. of N.Y. L. Rev. 77 (2016). <https://academicworks.cuny.edu/cgi/viewcontent.cgi?article=1414&context=clr>

⁴⁰ Dorothy Roberts, *Prison, Foster Care, and the Systemic Punishment of Black Mothers*, 59 UCLA L. REV. 1474 (2012).

⁴¹ National Council on Disability, *The Child Welfare System: Removal, Reunification, and Termination* (2012), at FN 275, available at <http://www.ncd.gov/publications/2012/Sep272012/Ch5#end>. Claire Chiamulera, *Representing Parents with Disabilities: Best Practice*, American Bar Association Resource: Child Law Practice Today, February 01, 2015, available at https://www.americanbar.org/groups/child_law/resources/child_law_practiceonline/child_law_practice/vol-34/february-2015/representing-parents-with-disabilities--best-practice/.

⁴² For example, in NY State, the law is clear that neither a pregnant woman, new mother, or newborn’s positive toxicology result for illicit drugs, alone, is sufficient to adjudicate a new mother as neglectful. See Nassau Cty. Dep’t of Soc. Servs. ex rel. Dante M. v. Denise J., 87 N.Y.2d 73, 79 (1995). No law or regulation requires or even advises medical care providers to call the child abuse and neglect hotline when a pregnant person, new mother or newborn tests positive for a controlled substance, or even requires such testing.

⁴³ Michelle Burrell, *What Can the Child Welfare System Learn in the Wake of the Floyd Decision?: A Comparison of Stop-And-Frisk Policing and Child Welfare Investigations*, 22 CUNY L. Rev. 124 (2019).

⁴⁴ See NAPW, *Medical and Public Health Group Statements Opposing Prosecution and Punishment of Pregnant Women* (2018), available at <http://advocatesforpregnantwomen.org/Medical%20and%20Public%20Health%20Group%20Statements%20revised%20June%202018.pdf>.

⁴⁵ See NAPW website generally for a wealth of information on this topic, available at www.advocatesforpregnantwomen.org

⁴⁶ See NY Times Editorial Board, *Slandering the Unborn*, NY Times, December 28, 2018, available at <https://www.nytimes.com/interactive/2018/12/28/opinion/crack-babies-racism.html>.

- ⁴⁷ Thomas, S., Treffers, R., Berglas, N. F., Drabble, L., & Roberts, S. C. M., *Drug Use During Pregnancy Policies in the United States From 1970 to 2016*. *Contemporary Drug Problems*, 45(4), 441–459 (2018), available at <https://doi.org/10.1177/0091450918790790>; John J. Prindle, Ivy Hammond, Emily Putnam-Hornstein, *Prenatal Substance Exposure Diagnosed at Birth and Infant Involvement with Child Protective Services*, *Child Abuse Negl.* 2018 Feb; 76:75-83 (Documenting prenatal drug use as a common pathway into foster system involvement for infants). One study showed that over 50% of doctors surveyed said they believed their drug using patients should be separated from their children. Abel EL, Kruger M, *Physician Attitudes Concerning Legal Coercion of Pregnant Alcohol and Drug Abusers*, *Am J Obstet Gynecol* 2002;186:768–72.
- ⁴⁸ Forthcoming NYU Law and Movement for Family Power report on Drug War and Child Welfare (2019) (on file with the author).
- ⁴⁹ National Survey on Drug Use and Health (NSDUH), *Results from the 2017 National Survey on Drug Use and Health*, available at <https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHDetailedTabs2017/NSDUHDetailedTabs2017.htm#lotsect5pe>
- ⁵⁰ Kunins et al., *The Effect of Race on Provider Decisions to Test for Illicit Drug Use in the Peripartum Setting*. *Journal of Women's Health* (2007); 16(2):245–255 available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2859171/pdf/nihms-182195.pdf> (Black women more likely to be tested).
- ⁵¹ E.g. Stephanie L. Rivaux, *The Intersection of Race, Poverty, and Risk: Understanding the Decision to Provide Services to Clients and to Remove Children*, *Child welfare* 87(2):151-68, February 2008, available at <https://www.ncbi.nlm.nih.gov/pubmed/18972936>.
- ⁵² Wisconsin Statutes Annotated section 48.133.
- ⁵³ *Loertscher v. Anderson*, 259 F.Supp.3d 902 (W.D. Wis. 2019).
- ⁵⁴ United Nations, Human Rights Council, Report of the Working Group on Arbitrary Detention on its visit to the United States of America, A/HRC/36/37/Add.2 (17 July 2017).
- ⁵⁵ American College of Obstetricians and Gynecologists, Committee Opinion, *Alcohol Abuse and Other Substance Use Disorders: Ethical Issues in Obstetric and Gynecologic Practice* (2013).
- ⁵⁶ American College of Obstetricians and Gynecologists, *Substance Abuse Reporting and Pregnancy: The Role of the Obstetrician-Gynecologist*, (January 2011, Reaffirmed 2019), available at <https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Substance-Abuse-Reporting-and-Pregnancy-The-Role-of-the-Obstetrician-Gynecologist?IsMobileSet=false> (noting: “The use of the legal system to address perinatal alcohol and substance abuse is inappropriate.”); Sarah C. M. Roberts and Cheri Pies, *Complex Calculations: How Drug Use During Pregnancy Becomes a Barrier to Prenatal Care*, *Matern Child Health J.* 2011 Apr; 15(3): 333–341. available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2904854/>; Elizabeth Wall Weiler, *Prenatal Care Among Women Involved With Child Protection Services*, *CMAJ*. 2019 Feb 25; 191(8):, available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6389455/#> (noting: Mothers whose first child was placed in out-of-home care had higher odds of receiving inadequate or no prenatal care in their next pregnancy than mothers whose children were not placed in out-of-home care.).
- ⁵⁷ Subbaraman MS, Roberts SCM, *Costs associated with policies regarding alcohol use during pregnancy: Results from 1972-2015 Vital Statistics*, *PLOS ONE* 14(5) (2019)
- ⁵⁸ Deborah A. Frank et al., Growth, Development, and Behavior in Early Childhood Following Prenatal Cocaine Exposure: A Systematic Review, 285 *JAMA* 1613 (2001). (1), Children’s Hospital of Philadelphia, *Neonatology Update: Poverty More Damaging Than Gestational Drug Exposure* (2013)
- ⁵⁹ See forthcoming NYU Law and Movement for Family Power report on Drug War and Child Welfare, *Supra note* 23.
- ⁶⁰ Alexa Richardson, *The Use Of Child Protective Services And Court Orders To Enforce Medical Compliance In The Labor and Delivery Room: How Threats of Legal Action Limit Reproductive Choice*, *Harvard Journal of Law and Gender*, November 2018, available at http://snip.ly/labhm#http://harvardjlg.com/2018/11/the-use-of-child-protective-services-and-court-orders-to-enforce-medical-compliance-in-the-labor-and-delivery-room-how-threats-of-legal-action-limit-reproductive-choice/?fbclid=IwAR29TnRAZ6t_ko47CDsze6_v6xFQnqU4uKEI4_pFlZ9NfzDknp4BgrUSZCM; Theresa Morris and Joan H. Robinson, “Forced and Coerced Cesarean Sections in the United States.” *Contexts* 16, no. 2 (May 2017): 24–29, available at <https://journals.sagepub.com/doi/10.1177/1536504217714259>.
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⁶² American College of Obstetricians and Gynecologists, *Refusal of Medically Recommended Treatment During Pregnancy*, June 2016, available at <https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Ethics/Refusal-of-Medically-Recommended-Treatment-During-Pregnancy?IsMobileSet=false>.

⁶³ Rachel Blustein, *The Paradox of Postpartum Depression*, *Colorlines*, July 13, 2018, available at <https://www.colorlines.com/articles/paradox-postpartum-depression>; Patricia Tomasi, Moms With Postpartum Depression Keep Getting Reported To Child Services, *Huffington Post*, February 13, 2018, available https://www.huffingtonpost.ca/2018/02/13/postpartum-depression-child-services_a_23360686/; NY Times, Letters to the Editor, Postpartum Depression, available at <https://www.nytimes.com/2014/06/22/opinion/sunday/postpartum-depression.html>.

⁶⁴ Elizabeth A. Howell, Pablo A. Mora, Carol R. Horowitz, and Howard Leventhal, *Racial and Ethnic Differences in Factors Association with Early Postpartum Depressive Symptoms*, ACOG, Vol. 105, No. 6, June 2005 (noting, “African-American and Hispanic women are at higher risk for reporting early postpartum depressive symptoms as compared with white mothers.”) available at <https://www.ncbi.nlm.nih.gov/pubmed/15932842>.

⁶⁵ Elizabeth A. Howell, et al., *Racial and Ethnic Differences in Factors Association with Early Postpartum Depressive Symptoms*, at 1448, 1449.

⁶⁶ See *Supra* note 3.

⁶⁷ See section above titled “The Impacts of Family Separation Are Devastating”

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