CITY COUNCIL
CITY OF NEW YORK

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TRANSCRIPT OF THE MINUTES

Of the

COMMITTEES FOR GENERAL WELFARE
JOINTLY WITH COMMITTEE ON HOSPITALS

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HELD AT: Council Chambers - City Hall

B E F O R E: STEPHEN T. LEVIN
Chairperson

CARLINA RIVERA
Chairperson

COUNCIL MEMBERS:
Ritchie J. Torres
Vanessa L. Gibson
Rafael Salamanca Jr.
Barry Grodenchik
Adrienne E. Adams
Antonio Reynoso
Brad Lander
Mark Treyger
Mark Levine
Diana Ayala
Francisco Moya
Antonio Reynoso
Mathieu Eugene
Alan N. Maisel

A P P E A R A N C E S (CONTINUED)

David Hansell, Commissioner
New York City Administration for Children's Services

Natalie Marks, Associate Commissioner for Quality Assurance
Division of Child Protection

Jessica Prince, Attorney
Family Defense Practice at Bronx Defenders

Brianne Ryer (sp?), Supervising Attorney
Family Defense Practice at the Neighborhood Defender Service of Harlem

Shakira Kennedy, NYC Resident

Robin Wiley, Parent Leader
Rise

Nyla Natarajan, Supervising Attorney
Brooklyn Defender Services in Family Defense Practice

Jane Cooper, Attorney
Legal Aid Society's Juvenile Rights Practice

Nahal Zamani (sp?), Advocacy Program Manager
Center for Constitutional Rights

Cassandra Frederique, New York State Director
Drug Policy Alliance

Clark Wheeler, Government Relations Associate
Planned Parenthood New York City

Greg Waltman
G1 Quantum

[background comments] [sound check]

SERGEANT-AT-ARMS: Check. Check. Check. Check. Check. Today is April 10th, 2019. Today's hearing is on general welfare joint with hospitals being recorded by Cherice and Israel.

[background comment]

CHAIRPERSON LEVIN: Good afternoon everybody. I'm Council member Steve Levin, Chair of the Council's Committee on General Welfare. Today we are holding a hearing to address the impact of marijuana policies on child welfare. Additionally, we will be hearing two reporting bills: Intros 1161 and 1426 to provide transparency to the process and two resolutions, number 740 and 746, calling for the clarification of marijuana policies and laws in regard to marijuana and child welfare. I want to thank my co-chair for today's hearing, Council member Carlina Rivera, for joining me and bringing this important topic to a hearing. Before we begin, I'd like to acknowledge Council members that are present, Council member Donovan Richards, and we expect to be joined by others throughout the hearing.

Marijuana use is quickly expanding across the country as more and more states legalize it. As

New York State contemplates legalization and marijuana use is rapidly becoming normalized, and it is incumbent upon us to scrutinize how our current laws and policies impact families and examine what corrections are needed. 15 percent of the 34,642 allegations that were referred to ACS between July and September 2020 teen were for parental or child substance abuse. That is a significant number of cases. While we know the opioid crisis has heavily influenced these numbers, we also know that a good chunk of these cases are for marijuana use. A child welfare investigation is a huge invasion into the privacy-- into someone's privacy and can be a threat to dignity away and ACS workers are calling and visiting your child's school, teachers, friends, the superintendent of your building, and neighbors just because you may have tested positive or said you were using marijuana. We need to ensure that ACS isn't wasting its time and resources on bogus reports and that families are not being subjected to unnecessary investigations and pressured into unneeded services to prove that they are the worthy enough to keep their children. Current state law is pretty clear that substance use alone is not a cause for

indicating a neglect case and that a child's physical, mental, or emotional condition must also be impaired over in imminent danger of becoming impaired due to a parent or guardian's failure to provide minimum care due to the quote unquote misusing of a jerk. According to the national advocate for pregnant women, there is no research that establishes a casual link between a person who is used some amount of controlled substances to the likelihood of abuse of a child. We need to correct our policies that continue to criminalize women, in particular women of color, further parenting. In a hearing this fall-- In the hearing last fall, ACS testified that marijuana use alone is not used to justify removing a child from the home, restrict per until visitations, or keep a child from being reunited with their parents. However, advocates have testified to the opposite being true. In the same hearing, Commissioner Hansell testified that she recused leading to inadequate guardianship could influence the child neglect case, but acknowledged that, quote, and adequate guardianship is a vague indicator. We need more clarity on this issue with or without legalization. Fake directives lead to wide

discretion and this discretion could lead to discrimination. As the drug policy alliance stated in their testimony in the fall hearing of this committee, quote, racism and classism combine to capture caregivers and cycles of surveillance and mandated unnecessary services that sever families who can't live up to the expectations of the court. Behaviors deeply scrutinized by ACS and Family Court judges in these cases would largely go unnoticed in more affluent white communities, close quote. We cannot allow this to continue. Today, our committees will be examining how ACS and the Health and Hospitals can work together to ensure that policies are clarified, parents and staff are educated, and children are kept safe without the trauma of unnecessary investigations and separations. In addition to hearing from ACS today, we also want to hear from parent advocates, drug policy advocates, healthcare providers, and legal services providers about the changes that are needed to ensure fair and equitable child welfare system. I would like to thank the Council staff for their very artwork today in preparing for the hearing. Counsel Amenta Kilowan (sp?) who has the flu, we wish her well and a speedy

recovery. Policy Analyst, Tonya Sirus and Crystal Pond, and Finance Analyst, Daniel Croup (sp?). I'd also like to thank my Legislative Director, Elizabeth Adams, and Chief of staff, Johnathan Buche (sp?). I'd also like to thank Commission David Hansel who has made many improvements at ACS in his relatively short time as Commissioner and his entire team who I know have the best interest of New York City's children at heart. And, with that, I want to turn it over to my colleague, Carlina Rivera.

CHAIRPERSON RIVERA: Thank you, Council member Levin. Good afternoon, everyone. Thanks for being here. I'm Council member Carlina Rivera of the Committee on Hospitals and I want to thank everyone for making it today. Today we are looking forward to hearing from the representatives of the ACS, as well as Health and Hospitals and other stakeholders about the impact of marijuana policies on child welfare. We will also discuss legislation and resolutions that aim to provide additional transparency on marijuana use among parents and the impact it has on their families, including resolution 746, which I am proud to sponsor. A number of people using marijuana during pregnancy has increased significantly in

recent years, as mentioned. According to one study from 2009 through 2016, the adjusted surveillance of prenatal marijuana use increased from 4.2 percent to 7.1 percent among patients in California. Marijuana is now easier to obtain legally and may, in some cases, be marketed as having the ability to assist with pregnancy related symptoms. Despite the increase in the use and marketing, we are still not certain about the impact marijuana can have on a pregnant person and their child. The current consensus is that no amount of marijuana has been shown to be safe during pregnancy and the research currently available has, for the most part, reported potentially negative impacts on children who are exposed to marijuana in the womb. However, some have argued that marijuana use is too often compounded with other drug use and or tobacco use, rendering research results imprecise. In fact, one study from 2016 concluded that marijuana use during pregnancy is not an independent risk factor for adverse neonatal outcomes after adjusting for confounding factors including tobacco. To summarize, we know marijuana use among pregnant people is increasing. We know that the science around it is cautionary, yet not

entirely clear and we know that the legalization of recreational marijuana is on the table which may increase its use. Despite the fact to the marijuana is used equally in different communities regardless of race and socioeconomic status, communities of color have been disproportionately impacted by the war on drugs. They impact on pregnant people and their families unsurprisingly reflects this. We know from a study conducted in 2007 that women who are black are more likely to be tested for drugs than their counterparts. We know that testing is significantly associated with black maternal race, single or widowed marital status, lower educational status, unemployment, public or absent health insurance, living in a neighborhood in the poorest quartile, as well as older age. Today we want to look critically at how these factors impact New York City families. I am especially interested in the impact drug testing has on people who give birth in our public hospital system. Currently, H&H's drug testing policies are not public and little is known about their implementation. We know that H&H tried tests parent based on the standards put forth by the American Congress of Obstetricians and Gynecologists,

the ACOG. Standards which include testing mothers who have not received or received little prenatal care and those with a history of drug use. We also know that ACOG believes seeking obstetric gynecologic care should not expose a woman to criminal or civil penalties for marijuana use such as the loss of custody of her children. We know that a drug test indicating marijuana use is not enough reason to initiate a call to ACS according to the state guidelines, yet 15 percent of the 34,642 allegations that were referred to ACS between July and September of 2018 were for substance abuse. Today, want us to address these figures. I want to hear about H&H's decision, making process, and why a doctor at H&H would choose to drug test pregnant people and their children. I want to make sure this testing is as fair an equitable as possible as well as uniform through the H&H system. Although a person must consent to have their urine or their child's urine tested, we must ensure this consent is being requested consistently and that testing is transparent and conducted in an unbiased manner. We also need to better understand the circumstances under which hospital staff would decide to initiate a

case with ACS and if the decision makers have a firm understanding of the consequences of getting ACS involved. The resolution I am sponsoring which calls on the state to pass legislation requiring the department of health to create clear and fair regulations for hospitals on drug testing those who are pregnant or giving birth would begin to address some of these issues. Still, unlike a law that-- until a law like this exists, we must continue to monitor our city hospitals and ensure fairness and equity. The cycle of inequity and systemic racism and oppression must be eradicated and this can only happen if we address these issues in an honest and open discussion. I look forward to hearing from H&H and ACS, as well as members of the community about their experiences. Thank you.

CHAIRPERSON LEVIN: Thank you, Chair Rivera. And before we turn it over to the Commissioner, I'd like to ask Council member Donovan Richards to deliver opening remarks on his legislation.

COUNCIL MEMBER RICHARDS: Thank you, Chairs. And I'm here today to discuss my legislation that was inspired by women of color and their

experiences and what has become known as the new Jane Crow. While the separation of a parent and their child due to marijuana can and does happen to anyone, women of color are overwhelmingly targeted. The separation may only last a few days or weeks is the parent is lucky, but the negative impacts can last a lifetime. I know the staff at the administration of Children's Services does incredibly tough and important work and, of course, we need to make sure children are safe and healthy in their homes, but I do want to be clear. The use of any drugs should never be the sole factor leading to a substantiated allocation of neglect. Last year, Shakira Kennedy stood on the steps of this very building with her twin baby boys swaddled in her arms to advocate for a change in the system. She also wrote an op-ed in the New York Daily News that I am going to paraphrase to tell some of her story. While she was pregnant with her twins, Ms. Kennedy suffered from extreme morning sickness and could not keep any food or water down. She consulted with her doctor and the only thing that helped her was the use of marijuana. Her children tested negative for marijuana, but ACS made her go to court and she was mandated to an outpatient rehab

program three days a week or risk losing her three children. She also was at risk for being flagged for child neglect if her case is not sealed which would leave her unable to work with children until her twins turned 28. As if it's not hard enough already for a single mother to find daycare or to go to work, imagine adding on this additional burden when there is no clear evidence of neglect. I have yet to see a study that confirms a correlation between marijuana use and adverse neonatal outcomes, but I would like to see the information that ACS is using to make the determination that allegations of usage or proof of usage is evident of neglect. I'd also like to see how often this determination is used and which agency is making these determinations or recommendations, but currently none of that information is public for marijuana or any other reason. Which brings us to Intro 1161 which would require ACS to report on the main allegations that lead to a report or the opening of a case for investigation of child abuse or neglect. The allegations would specifically include, but not be limited to, for example, a parent's or caretaker's marijuana usage, inadequate food, clothing, shelter, or other specified allegations.

This information, in no way is meant to protect abusive parents. It's goal is to ensure that we are not mislabeling good parents and marking them as abusive for nearly three decades. We have, unfortunately, watch the pain of family separation day after day on our southern border, but the fact of the matter is this happens every day in our city and those stories aren't told as often. We have to do better. We have to be more compassionate and we have to stop tearing apart families over marijuana. I want to thank the Chairs once again for holding this important hearing, critical hearing, in terms of stabilizing communities and families and I look forward to hearing whether you support the legislation or not. Thank you.

CHAIRPERSON LEVIN: Thank you, Council member Richards. Council member Lander for opening remarks, as well.

COUNCIL MEMBER LANDER: Thank you, Chair Levin and Chair Rivera. I have the resolution that, in many ways, it is apparent to Council member Richards intro. The intro is what would require recording. The reso is what makes clear the Council's strong intention, the point behind it, to

be that we need to not use marijuana possession or use or cultivation as the pretense for or the reason for family separation and taking children. You know, I am glad that we are in a world where we are all moving away from that and coming to recognize what harm we've done. I note that in the testimony you are going to give you speak to the December 2018 task force report that reflects many of the same-- the same point of view we are coming to here today. So, I am glad that we are moving in that direction. I don't want us to kind of paper over the harm we've collectively done on all of those. We didn't pass these legislations or resolution before. The city has not had this set of policies before. So, you know, it's good that we are finally getting here. You know, we have led a set of policies around marijuana and drug use presumption and incarceration to a lot of harm to families and thankfully we are moving towards a better day, but I do think it is important for us to honestly reckon with what we have done together and that is not more on the administration than it is on the Council, but I also want to not pretend it away like because we have sort of woken up to better policy we don't own what we

have done together. So, anyway, that said, I appreciate the hearing. I appreciate the legislation. I look forward to the testimony. Thank you.

COUNCIL MEMBER RIVERA: I want to just briefly acknowledge members of my committee that have joined us. Council members Eugene, Maisel, Ayala, and Moya.

COUNCIL MEMBER LEVIN: And I'll acknowledge members of the General Welfare Committee that have joined. Council member Grodenchik, Council member Adams, Council member Ayala in spirit as just left the committee, and Council member Lander. Okay. I will swear-- I will ask Council committee to slur you in.

LEGAL COUNSEL: Do you affirm to tell the truth, the whole truth, and nothing but the truth in your testimony before this committee and to respond honestly to Council member questions?

COMMISSIONER HANSELL: I do.

DR. MICHELLE ALLEN: I do.

COMMISSIONER HANSELL: All right. Good afternoon, Chair Levin, Chair Rivera, members of the Committees on General Welfare's and hospitals. I am

David Hansell, Commissioner of the New York City Administration for Children's Services. With me today, to my right, is Natalie Marks, Associate Commissioner for Quality Assurance for our division of Child Protection. We are pleased to join you today to share more about the work ACS is currently doing to protect safety and promote family well-being particularly in cases where there have been allegations and or concerns about substance misuse, including marijuana, as well as the work ahead as we prepare for the possible legalization of marijuana. We are also joined to my left by Dr. Michelle Allen, senior vice president and chief medical officer of New York City Health and Hospitals who is here to answer any questions about Health and Hospitals policies and practices. ACS' core mission is to protect and promote the safety and well-being of New York City's children and families. I think we all knowledge the reality that there are children who experience devastating and tragic neglect while in the care of the adults who abuse drugs or alcohol and it is ACS's responsibility to discern when that danger exists and take action to forestall it. However, in all of our cases, including those with

substance misuse allocations, we assessed child safety on a case by case basis looking at actual or potential harm to a child and, if it exists, the parent's capacity to safely care for the child. Curry stayed in city policy and child welfare best practice is that a parent's use of a substance, legal or illegal is not in and of itself a basis for finding them neglect, much less for a child's removal or other court action. As we anticipate the decriminalization of marijuana, these principles must guide our response and, as I will explain, we continually review our practice is to ensure that they are consistent with these principles as they are embodied in our policies. The characterization of marijuana as an illegal substance is under wide review as lawmakers in Albany continue to discuss possible legalization in New York State. Marriage blasé out has endorsed to the decriminalization of marijuana and has already taken steps to prepare the city for this eventuality. In addition to changes in the cities marijuana enforcement policies that have been instituted by this administration, the mayor formed the task force on cannabis legalization, the task force says I will refer to it, last summer which

has worked to develop goals, identify challenges, and make recommendations to guide the city's preparation for legalization should a law change occur. Along with other city agencies, ACS has been an active member of this task force. And in December of last year, the task force released a report with legislative, regulatory, and policy recommendations to help guide the states discussion on marijuana legalization and to identify the goals and challenges that should guide the city's preparations for potential legalization. One of these recommendations is directly related to ACS's work and clearly states that parental rights should not be impaired on the basis of cannabis use or cultivation unless it is endangering a child. A principal with which we concur and which is sensual to our current policies and practices. Let me begin by briefly describing the reporting and investigation framework for our work. When a person, anyone in New York City's suspects that the child is being abused or maltreated, they may make a report to the New York State-wide Central Register of Child Abuse and Maltreatment, or the SCR, which is administered by our state oversight agency, the office of Children

and Family Services. If the state accepts the report, the report is sent directly to the appropriate County, ACS for the five boroughs, to investigate. ACS has no discretion as to whether to conduct an investigation if the state accepts the report. We then have up to 60 days to conduct an investigation. Each year, on average, we conducted about 60,000 investigations that involve about 90,000 children. About 20 to 25 percent of these investigations include allegations of substance misuse, usually together with other allegations. ACS is goal during any child protective investigation is to assess child safety. All families and children are different and our staff is charged with making highly individualized nuanced assessments based on risks and strengths and to then take appropriate actions, if necessary, to ensure child's safety. By both state and local policy, neither a positive drug test of a parent nor a positive toxicology of a newborn baby is, in itself, a basis for the determination that evidence of abuse or neglect exists. When investigating allegations of substance misuse, including misuse of marijuana, child protection staff must evaluate whether the parent or

caretaker's substance misuse has created a condition where the child's physical, mental, or emotional condition is negatively impacted or is in imminent danger of becoming negatively impacted. And then must assess whether the parent's ability to care for and safeguard the child in the home is impacted by their substance misuse. To assist our child protective staff in cases involving substance use or misuse, ACS utilizes credentialed alcoholism and substance abuse counselors, generally known as CASACS, as part of our clinical consultation team. CASACS are certified substance abuse experts who are available to all of our CPS to provide support and technical assistance when Child protective staff are assessing safety and risk in cases involving substance misuse allegations. The child protection team works with the family to provide supports and respond to service needs that are identified as a result of the investigation. In the vast majority of cases in which ACS identifies an actual or potential risk to children, we work to keep those children at home with their parents or caretakers by engaging the family and prevention services. Where substance misuse is a safety concern, staff may make a referral

for voluntary prevention services and or drug treatment for substance misuse. Our full continuum of prevention services is available to families where there is a substance misuse issue impacting safety. We work to best match a family's means to the right type of service which could include a general prevention service, our family treatment and rehabilitation services or FTR as we call them, our special medical services, or one of our evidence-based models of prevention services. Depending on the severity of the substance misuse concern and other service needs the parent may have, the prevention services provider may work in partnership with a substance abuse treatment program to address the parent or caretaker's substance misuse and mitigate risk to the children in the home. And higher risk cases where the primary safety concern is the parent or caregiver's substance misuse or mental health disorder, CPS may refer of the family for FTR services. Our FTR programs offer clinical diagnostic teams comprised of licensed therapists, CASACS, case planners, psychologist consultants, psychiatric consultants, and other providers who can work with families to develop treatment plans to address risk

factors and bolster child safety. More recently, we've begun to identify supports that we can offer to families and communities independent of child welfare involvement with the goal of avoiding such involvement altogether. Our division of Child and family well-being is developing a set of services, community level interventions, and public education activities that can build on parent's strengths and protective capacities. Let me provide one relevant example. As you probably know, approximately 50 infants in New York City died every year because of unsafe sleep practices. Most often that involves bed sharing by parents with an infant. And, tragically, that often occurs when a parent is under the influence of alcohol or drugs. To help parents avoid this risk, just last month we completed our citywide rollout in partnership with Health and Hospitals to distribute our safe sleep toolkits to maternity patients on all the cities 11 Health and Hospitals maternity facilities. The kits contain educational materials designed to be taken home by parents to share with family members and others who help take care of the new baby and will reinforce the safe sleep information that hospital staff are required by

law to provide to maternity patients at the time of discharge. The kids also include a safe sleep brochure, a DVD, a wearable blanket or sleep sack, crib netting, an infant onesie, and a board book called Sleep Baby: Safe and Snug. This is one example of our focus on trying to identify services and supports that can assist parents in caring for their children and keeping them safe. So, in summary, ACS's current policy requires our child protective staff to assess the impact a parent's substance misuse may be having on a child regardless of whether the substance is alcohol, marijuana, prescribed drugs, or illicit opioids. Our goal in our practice is to intervene with drug treatment or prevention services to keep children safe at home whenever that is possible. Now, while the legal context for marijuana may shift soon at the state level, we are committed to continuing our work with our sister city agencies to ensure that our policies and our practice is evolve congruently with any future changes in the law. As a member of the task force, ACS help to develop and shape section 2 recommendation number 14 of the December report, which is captioned, parental rights should not be

impaired on the basis of cannabis use or cultivation unless endangering a child. ACS strongly endorses this recommendation which includes the following components:

Number one, child custody or visitation should not be denied on the basis of cannabis use or cultivation unless that place is a child in danger. Our top priority for every family we encounter is the safety of the children and this recommendation the lines with the agency's commitment to family preservation and child safety and is also consistent with our current foster care policies. Part two of the recommendations says that no child should be subject-- should be the subject of a child neglect or abuse investigation or proceeding based solely on the parents allegedly use of cannabis. Anyone who suspects that a child is being abused or neglected can call the state central registry to make a report and the state decides whether to accept that report. As I said earlier, it's the state accepts the report on a New York City child, ACS has no discretion as to whether to investigate the report. We are required by law to do so. But the state should not accept and refer for investigation reports that to not contain

allegations of risk to a child such as reports based solely on a parent's alleged use of cannabis. We have been in conversations with the state office of children and family services and are verifying that the SCR does not accept substance use related complaints nor refer cases to ACS to investigate when there is no allegation of impact on child safety. Part three of the recommendation says that cannabis use or cultivation should not generate a presumption of child neglect or endangerment. The focus of our investigations is on determining whether parents actions and impact on child safety or create a risk to children and the use of cannabis in and of itself does not equate with risk of harm. Part four of the recommendation states that a positive cannabis test in and of itself should not equate automatically to a compelling measure of maltreatment in the context of child welfare and, again, our current policy and procedures require ACS to the base safety and risk assessments on the impact the substance misuse may have on child safety. A positive cannabis test, in itself, should never be considered maltreatment. And, fifth, the recommendation states that cannabis should be defined as equivalent to quote unquote drug

in the Family Court act in order to remain within the ambit as substances that can lead to investigation or supervision of parents if a child is in danger by parental use even if that cannabis use is not criminalized at the state level. In effect, cannabis use should be treated the same as alcohol use in the context of child custody. And, as previously stated, our concern is not cannabis use itself, but the impact it could have on child safety and that is the focus of our investigations and we will maintain that focus regardless of the criminality status of cannabis. So this task force recommendation is consistent with ACS's policy. Now, as in all areas of our work, we are constantly striving to ensure that our case practice is universally consistent with our policies. Similarly here, with regards to parents use or misuse of marijuana, we take active steps to ensure that our practice is aligned with all applicable policies. To do this, we use a robust quality assurance and oversight mechanisms to reinforce child stat, supervisory case reviews, provider agency monitoring system, case audits, and our annual collaborative quality improvement plans for all of our providers. We also recognize that the

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

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

Beginning with Intro 1161, we very much appreciate the Council's interest in better understanding the types of allegations that ACS investigates. We currently provide quarterly child welfare reports to the Council pursuant to local law 20 of 2006. This proposed Intro would amend the law to require ACS to disaggregate our current child welfare quarterly report by the numerous specific allegation types listed in the build. We are required to use the state's system of record which is called connections to track child welfare cases. Due to limitations in the connection system, we don't currently have the technical capacity to aggregate allegation data regarding use of marijuana or any specific drug, for that matter. The state has launched new upgrades to connections in mid-January of this year which will eventually allow us to develop some new reporting functionality. While there hasn't yet been training on the new fields, the state did just recently released some preliminary guidance at the end of March regarding the use of the new fields which include drop downs for child protective staff to select specific substances parents or caretakers are found to be using or

misusing. According to the guidance from the state, however, the state doesn't intend to functionality to track the specific drugs in child welfare obligations, which is what the city Council legislation is seeking ACS to report on. We are currently having additional conversations with the state to see if the system can provide greater specificity with regard to maltreatment allegations and whether it could provide the capacity in the future to capture specific drugs in those allegations. And also we are still clarifying with the state how the new data will be accessible for data reporting by ACS. So we look forward to discussing this further with the Council as soon as we have more clarity from the state. The current quarterly child welfare report also includes a number of child welfare related statistics. Some elements of which are now outdated including items related to caseload and workload. As you know, local law 18 of 2018 requires ACS to conduct a workload study pertaining to our CPS staff which is currently underway. We are due to issue a report on the findings of this study to the Council in September of this year and we anticipate that the information in

that report will be useful in informing amendments to local law 20. We are committed to transparent information sharing with the Council and we are happy to engage in further discussion about how best to update local law 20 to be useful and informative to the Council and other stakeholders. And we look forward to working with the Council on options that could be available given ACS's current day limitations relating to the statewide system of record. We would respectfully urge the Council to hold Intro 1161 pending further conversation with us and submission of the agency's workload study report in September.

Turning to Intro 1426, this proposed legislation would require ACS to report annually on the number, type, and outcomes of investigations initiated by ACS as a result of positive drug screens from drug tests performed in facilities managed by New York City Health and Hospitals. The proposed bill would also require us to disaggregate this information by H&H's facility by a number of other factors such as age, income, gender, ethnicity, date of drug test, different types of drugs, number of investigations initiated by ACS, and the outcomes of

those investigations. We appreciate the Council's intent to better understand systems and processes that affect the everyday lives of New Yorkers. A core part of our agency's vision is to identify and confront the disproportionate impact that the child welfare system has had on historically marginal groups. ACS is taking important steps to address these issues through primary prevention services and equity focused initiatives. However, this build presents a number of operational concerns and other challenges that, again, we look forward to discussing further with the Council. As written, the bill does not accurately capture the process of how a family might come to the attention of ACS which, in turn, would create fundamental operational challenges for us in producing the report that the bill envisions. The draft bill presumes that H&H would be referring cases to ACS directly and that ACS would determine when to do an investigation. This actually does not happen. Whenever a report of suspected abuse or maltreatment is made, that report goes to New York State to the SCR. The state determines whether to accept to the report and, if it does, it sends it to the appropriate county to investigate. And, by law,

as I said, ACS is required to investigate any report we received from the state. We have no discretion with regard to determining whether to conduct an investigation. In addition, the bill would require ACS to disaggregate the data in ways that are not currently technologically able to do and, in some instances, may not have the requested information at all. Also, we are concerned about the unintended consequences that could arise from legislation requiring the collection of personal information and then public reporting of those data. This reporting requirement could create a chilling effect on reporter's willingness to call the SCR even when there might be a serious child safety risk and that might also dissuade people from seeking medical attention to avoid having their personal information shared with government entities for the purpose of collecting data for a public report. Finally, we are concerned about the level of specificity in the aggregation required by the proposed bill could unintentionally impact the parent's confidentiality. So, in closing, I want to thank you for the opportunity to discuss how the legalization of marijuana would impact child welfare. To reiterate"

from the recommendations from the mayor's task force, cannabis use should not generate a presumption of child neglect, neglect or endangerment, and nor showed a positive test, and in and of itself, quite automatically to a compelling measure of maltreatment in the context of child welfare. Our case specific determinations now and in the future must focus on the safety of children and the support of families. We also thank you for the opportunity to discuss the city Council's proposed legislation. We appreciate the Council's leadership and focus on these important topics and look forward to working with you to refine the bills so that they can best serve the interest of New York City's children and families and the dedicated workforce that serve them and we are happy to take your questions.

CHAIRPERSON LEVIN: Thank you, Commissioner. Council member Reynoso has opening remarks on his legislation.

COUNCIL MEMBER REYNOSO: So, I'm going to do for my opening remarks for questions, so I will wait for the questions around. Thank you, though, Council member Levin.

CHAIRPERSON LEVIN: Thank you, Council member Reynoso.

CHAIRPERSON RIVERA: Thank you. So thank you. Thank you so much. I wanted to ask a little bit-- Actually, let me start with just a task force question. So, you have recommendations that came out of the task force which seem aligned with our principles and values. What is going to happen with the recommendations and where's the task force going? If you could just give us a very brief kind of summary.

COMMISSIONER HANSELL: Yeah. Well, the task force recommendations, I think, were essentially twofold. One was there were recommendations to the state and to the state legislature about how it should proceed with decriminalization of marijuana and I assume the state legislature will do what it wishes with those. But they were also intended and directed to city agencies to make sure that our policies are aligned with them so that all of the members, and there were many city agencies represented on the task force, including ACS who contributed to it. The goal is to make sure that our policies are-- and our practices are aligned with

the recommendations and that is a review that we have been doing at ACS since December when that was issued. As I said in the testimony, we believe that our policies are aligned although we continue to review to make sure that's the case. And, certainly, as the law changes at the state level we will then do a review based on compliance with the law and any guidance we get from the state around the legislation. And then the other thing that we are continuously engaged in is making sure that our practice, as we investigate every allegation we receive, as we interact with every family, making sure that the practice is aligned with those policies which, in turn, must be aligned with the task force's recommendations.

CHAIRPERSON RIVERA: So we are here today having a hearing regarding introductions, as well as resolutions because I think what's most concerning is that, even though you seem to very aligned with how we feel on how these reports should be handled and investigated, you do have very limited discretion when it comes to the state office. So we are looking to also lobbying our colleagues in Albany to make those changes. So I am going to stick with

some questions about H&H's testing policy to get a little more clarification on how that works. And thank you Dr. Allen for being here. So, what is H&H's drug testing policy?

DR. MICHELLE ALLEN: So, we have a corporate policy for testing mothers which is really based on signs and symptoms of drug use. And the purpose of the testing is to identify women who are using drugs and two, based on a medical model, provide them the appropriate treatment. I've actually been working with substance abusing moms and moms who are at risk for HIV since 1982 when I was at Harlem Hospital and established a special prenatal clinic within the methadone clinic at Harlem Hospital to emphasize the medical model and, when I went to Bellevue in 1988, established a special prenatal care clinic there, as well, for women who were substance using, at risk for HIV infection, and also victims of domestic violence. In the care we provided there was a family centered care. A multidisciplinary where we actually had a designated nurse, designated social worker, designated psychologist, and had HIV counselors, as well. And the purpose of our teamwork was to make sure that the mother was safe during her

pregnancy. We had established a one-to-one relationship with the patients and acknowledged that our mutual goal was for her to get to the term, a full term pregnancy, with an appropriate born child, drug-free with an intact mother child dyad on the time of discharge. We do urine drug toxicology is just to establish a basis of truth and transparency so that we know when we become drug-free, we know if we are still using, we know if there is more intervention that is needed. The criteria for testing a mom during pregnancy include a number of things including whether she shows up with no prenatal care at the time of delivery, whether she has had limited prenatal care, whether she is exhibiting inappropriate behaviors such as [inaudible 00:44:52], loose associations, etc. We look at physical signs of substance abuse or, in fact come up withdrawal, if she is obviously inebriated or intoxicated, whether she has had any recent history of substance abuse or treatment, whether there is an unexplained fetal demise would be an indication for drug testing. Placental abruption is known to be a complication of cocaine use, so if someone presents with no prenatal care and a placental abruption, it

will result in a drug test. And, in addition, stroke or heart attack, smoking crack, using cocaine is actually been related to intracerebral hemorrhage and strokes than women who are pregnant and women who are not pregnant or abnormal mood swings. So those are the criteria for testing and the purpose of testing is to make sure that the patient, perspective mom, has a full-term pregnancy without complications and delivers drug-free and maintenance of the mother child dyad.

CHAIRPERSON RIVERA: Where can you find this policy? Is it public?

DR. MICHELLE ALLEN: It's not public. It's on our-- it's an internal document that is available for all staff at H&H.

CHAIRPERSON RIVERA: can a patient requests the policy?

DR. MICHELLE ALLEN: To date, they have not, but since it's not public, I don't think it would be readily available for her.

CHAIRPERSON RIVERA: So, how are they informed of the policy?

DR. MICHELLE ALLEN: At the time of-- We are instructed-- Based on the policy, we cannot

get a urine toxicology without her consent. So, at the time of broaching the subject of urine toxicology, our policies says she must be informed. She must know why. She must know the risks and she must know the benefits. So there needs to be a conversation and informed consent. If she doesn't consent, she is not tested.

CHAIRPERSON RIVERA: So you do tell the patient about possible legal consequences?

DR. MICHELLE ALLEN: We do inform her of that.

CHAIRPERSON RIVERA: How do you document the informed consent?

DR. MICHELLE ALLEN: The policy states that the conversation needs to be documented in the medical records. That the conversation took place, that the patient was informed of the benefits and the risks.

CHAIRPERSON RIVERA: So it's a doctor's note?

DR. MICHELLE ALLEN: It would be in the doctor's note.

CHAIRPERSON RIVERA: So, she doesn't sign anything? There's no like con-- like I've received this--

DR. MICHELLE ALLEN: It's not-- There's no written affirmation of having received this information.

CHAIRPERSON RIVERA: So, you mentioned all the indicators, including something like limited prenatal care. How do you determine these indicators? And the reason why I ask is because H&H serves an incredibly diverse population of New Yorkers including people with a limited understanding of the health care system. So even though when you're pregnant, you do have the resources if you know how to access them to get prenatal care. Many people don't have that information. Maybe it's a language barrier.

DR. MICHELLE ALLEN: Absolutely.

CHAIRPERSON RIVERA: Maybe if they're afraid to seek these services because of the political climate that we are in. So how do you determine these indicators and what do you do to make sure that people understand all the risks and--

DR. MICHELLE ALLEN: Uh-hm.

CHAIRPERSON RIVERA: and how you clarify how the results are going to be used?

DR. MICHELLE ALLEN: So, absolutely. You are 100 percent correct. Our patients come from all over the world. Many of them don't speak English and I need to say that we actually-- we take care of everybody whether they're-- no matter race, risk, ethnicity, religion, immigration status, literacy level. And very cognitive and sensitive to not only whether patients are able to speak and understand English, but what their medical health literacy is, as well. So we do not pretend to speak of patients of their language. We are actually mandated to have, is not a personal interpreter in the room, we actually access the AT&T operators so we have dual handset phones so that we are speaking in the patient's-- the patient can actually-- it's being translated. Whatever we are saying, it's translated back to the patient. Whatever the patient says, it's translated back to us. And, usually, with informed consent, what we like to use is the read back method or the talkback method. If I say to you I'm going to test your urine. You told me you have had a history of drugs use. As part of my prenatal care to make

sure that we have an honest conversation and we both agree that we want to be drug-free at the end of the pregnancy, I would like to do a urine pregnancy test. Not a pregnancy test. A urine drug test. And then I will ask you, do you understand what I just said? Can you tell me what it is I have just said to you? Because I think we all know, even in our personal relationships, what I say to you may not exactly the what you hear. There is often a disconnect between what people say and what the recipient years. So it's very important to get the patient to reiterate what you said so that you are very clear that they have understood you.

CHAIRPERSON RIVERA: So, when you ask a mother whether she is going to be tested or whether the child, the infant, is going to be tested, is the consent the same way? It's a doctor's note in which she verbally said it was okay?

DR. MICHELLE ALLEN: Yes. So the difference in the-- I don't test the babies. So, it's the pediatrician and it's the same set up. It's the same conversation. The pediatrician has the conversation with the mom to get her consent. If the baby is actively withdrawing, showing signs or

symptoms of drug toxicity as with cocaine or withdrawing as with heroin, for medical reasons, if the mother refuses to consent, for medical reasons, the child would have to be tested so if there is a differential diagnosis and you have ruled out everything else, you need to know what the cause is. Is it infantile seizures? Nausea, vomiting, diarrhea, etc.

CHAIRPERSON RIVERA: So, I just want to confirm. There is nothing in writing that is memorializing consent to testing?

DR. MICHELLE ALLEN: Other than the doctor's note in the chart.

CHAIRPERSON RIVERA: Other than the doctor's note.

DR. MICHELLE ALLEN: Yeah.

CHAIRPERSON RIVERA: How is the staff trained regarding the drug testing policy?

DR. MICHELLE ALLEN: The staff is trained by in services within the specific facility and the specific service. We have the opportunity to train at the CMO level, at the service director level, and at the front line staff level.

CHAIRPERSON RIVERA: So, we are always concerned about implicit bias and I know you mentioned training. And I will ask about that in a second. And we know that H&H, can-- you serve this immensely diverse population and I know just in Elmhurst Hospital alone there is, you know, well over 100 languages spoken, so I appreciate you addressing the language barrier. What percentage of pregnant people who are color or drug tested?

DR. MICHELLE ALLEN: So we actually do not put in your medical records of patients race, ethnicity, or citizenship status and when we send laboratory data to the lab, whether it is blood or urine, we do not document patient's race or ethnicity. It's not a formal field that is tracked, monitored, or reported on clinically.

COMMISSIONER RIVERA: So, when the person-- Right. So, when the person-- I'm just curious to, I guess, why considering that there was a lengthy-- and I realize there is confidentiality issues and there are ways of reporting data to not reveal someone's identity or breach confidentiality, but when you are talking about a language barrier and you are either establishing some sort of hotline or,

as is said, of personal interpreter, which I also think can sometimes be problematic considering technical expertise in language. How do you determine when someone should have access to an interpreter?

DR. MICHELLE ALLEN: So, we need to ask not only what is the primary language, but what is your preferred language? And we communicate with the patients with their preferred language. So you may have someone who actually is a native Spanish speaker, but prefers to speak in English, then we will use their preferred language. Or maybe bilingual and actually would prefer to speak in Spanish. So that is something that we all document in our medical records.

COMMISSIONER RIVERA: So, you don't have-- You have no data right now of whether there is a percentage of white patients versus immigrants, for example, being tested?

DR. MICHELLE ALLEN: Absolutely do not track immigrant status. So I can say in the general population, the demographics of Bellevue Hospital, we have across the system, about 1.3 percent of patients do not self-identify as any race. We have 5.48

percent Asian, 34 percent black, 39 percent Hispanic, 7 percent white. So we know what our general demographics are.

COMMISSIONER RIVERA: So you have by race who's drug tested and who is not.

DR. MICHELLE ALLEN: Right. We have just demographics across--

COMMISSIONER RIVERA: Because we saw-- I think you noticed in our testimony we're very concerned with how the disparity between how mothers of color are tested with more frequency-- more frequently, excuse me, than non-- than white mothers. So, how do H&H drug testing levels compare to other New York City based hospitals?

DR. MICHELLE ALLEN: I have no idea. I don't have that data.

COMMISSIONER RIVERA: And--

DR. MICHELLE ALLEN: I do have to say that we are very sensitive to disparities. As you know, from recent literature, and we're known this a while, that throughout the healthcare system, there's been inequity and including minority patients, including women in clinical trials and, as you know, there's been in the lay press as well as in our

literature, the disparities in terms of maternal morbidity and mortality and outcomes, we are very sensitive to that. We are in the process of training our entire staff throughout H&H on unconscious bias. We've established online modules, as well. We're working very closely with DOHMH on the maternity side with trauma-- training around trauma-informed care as well as unconscious bias. So this is something that we are very sensitive to. We feel very strongly about it. We are also implementing that on all level [00:55:36] from our chief medical officers to our chief nursing officers to our front line staff and OBGYN and then the online modules for the entire staff.

COMMISSIONER RIVERA: And I just have just two last questions before I turn it over to my co-chair. What if a person does not consent? What happens?

DR. MICHELLE ALLEN: Don't test. We don't test the mom without consent.

COMMISSIONER RIVERA: And that's documented in the file, as well?

DR. MICHELLE ALLEN: It's documented that she refused consent.

COMMISSIONER RIVERA: What happens if a pregnant person-- a person who just gave birth or the newborn test positive for marijuana?

DR. MICHELLE ALLEN: The newborn test is positive for marijuana. Is that your question?

COMMISSIONER RIVERA: It's what happens if the person, even if it's the pregnant person, they do test positive.

DR. MICHELLE ALLEN: So, we-- Our purpose of testing is for medical purposes. To identify patients who actually need treatment. We do not refer anybody to the state central registry for child abuse and neglect. We just-- The obstetrician just does not do that.

COMMISSIONER RIVERA: So does the mother know when-- That she can refuse consent?

DR. MICHELLE ALLEN: Oh. Absolutely.

COMMISSIONER RIVERA: And this is through the verbal policy--

DR. MICHELLE ALLEN: [interposing] Yeah.

COMMISSIONER RIVERA: that is told between the doctor and patient that's documented by the doctor in the file.

DR. MICHELLE ALLEN: Right.

COMMISSIONER RIVERA: Okay. Thank you so much for answering my questions. I'm going to turn it over to my co-chair.

COMMISSIONER LEVIN: Thank you very much, Chair Rivera. I want to also acknowledge Council member Mark Treyger has been joined us and thank you very much for your answers, Dr. Allen. I do want to follow up a few questions around Health and Hospitals, if that's okay. First question, I wasn't quite clear. In response to Council member Rivera's question about why we don't track race or ethnicity in terms of the number of times people are test at Health and Hospitals are give those-- administered those tests. Do we not believe that that would be instructive in terms of identifying potential implicit bias within our Health and Hospitals system if we were able to track that?

DR. MICHELLE ALLEN: Yeah. So, first of all, it's not part of the-- As I said, it's not part of the clinical record at all.

COMMISSIONER LEVIN: Uh-hm.

DR. MICHELLE ALLEN: I agree with you it would be very important for us to be informed of

situations where there are more than unconscious bias, but, in fact, explicit bias.

COMMISSIONER LEVIN: Right.

DR. MICHELLE ALLEN: I think from a systems perspective, we are committed to taking care of all patients equitably, whether they are from Pakistan, Vietnam, Eastern Europe, West Africa--

COMMISSIONER LEVIN: Sure.

DR. MICHELLE ALLEN: And being that greater than 90 percent of our patients are of color, it would be hard for us to say that we treat of color patients better than Caucasian patients since we have very few Caucasian patients.

COMMISSIONER LEVIN: Right. Right. I mean, the-- I-- Even so, there's data that we could extrapolate from-- if we were to have that information. You know, the same way that we have been able to extrapolate from marijuana arrests how marijuana is being policed in New York City.

DR. MICHELLE ALLEN: I think that's very important information. Would have-- We're very much open to figuring out how to do that without having the race be actually used against the patient. So--

COMMISSIONER LEVIN: Okay.

DR. MICHELLE ALLEN: I'm very happy to discuss further with you how we could best do that and track that.

COMMISSIONER LEVIN: So, I'm sure you're familiar. There was an article in Rolling Stone from last fall that spoke about a specific case of a mother in Brooklyn who used marijuana during her second pregnancy for-- to relieve nausea and volunteered the information to her obstetrician and, upon the birth of her children, had an ACS case called in or SCR case and-- well, the case was eventually dismissed. There was an investigation. I think there might have been some intervention. I don't know if there were preventative services, but, in that case, you know, there were some consequences exclusively for her use of marijuana during pregnancy and I'm just wondering how this all-- my question is I understand policy--

DR. MICHELLE ALLEN: Uh-huh.

COMMISSIONER LEVIN: but I'm not quite sure if the translates to practice--

DR. MICHELLE ALLEN: Uh-hm.

COMMISSIONER LEVIN: all the time. And so, I mean, without getting into-- I mean, I'm sure

you can't speak to the details of the case. I don't even know is the was-- if the children were born a Health and Hospitals hospital, but it-- it highlights a kind-- she can't be the only one--

DR. MICHELLE ALLEN: Right. And it--

COMMISSIONER LEVIN: who had that experience.

DR. MICHELLE ALLEN: Right. And it is of concern. I just have to say, for the most part, our providers know what our expectations are, know what our policies are, and for the most part comply with those policies. I think there will be rare exceptions and I'm as concerned as you are how frequently this happens through the city whether it's in the voluntary sector or in the public sector. On your opening remarks, Councilwoman Rivera, you mentioned NAPW and I have worked with them very closely. I'm very much aware of the criminalization and incarceration disproportionately to women of color and we, as a sys-- as an enterprise, feel very strongly to be-- to not allow that to happen within that system's and would be very open if, as you hear of things, to share them with us because we are always looking to improve. We don't think to know

about-- we don't like to hear about that-- those stories and, more than that, we don't want them occurring in our facilities.

COMMISSIONER LEVIN: Okay.

COMMISSIONER RIVERA: I think our-- And I appreciate you saying that. I think our issue is that there's not only no data tracked. Even though you know the race of patients, there's no data tracked on the people that are being served. In terms of also getting consent, how do we know the conversation remains the same from doctor to doctor when there's no uniformed policy memorialized? I don't think a doctor's note is sufficient and I've found the answers a bit underwhelming and I think that, if we can maybe work together to figure out, you know, what are the steps to getting that confirmed consent. How do we make sure they get the interpreter? That they know what's going on? The legal consequences. It seems it's all, you know, a written line and you have some talented and brilliant physicians and nurses and physician assistants in the H&H system, however, with nothing uniform, it seems that discretion can lead to some serious problems and challenges. So--

DR. MICHELLE ALLEN: You're absolutely right. You're absolutely--

COMMISSIONER RIVERA: I just wanted--

DR. MICHELLE ALLEN: right.

COMMISSIONER RIVERA: to put that-- I didn't want to interrupt my colleague, but we find no data tracking and no uniform way to confirm consent when there are clearly obstacles in communication--

DR. MICHELLE ALLEN: Uh-hm.

COMMISSIONER RIVERA: and limited understanding in proficiency, not just in language, but in a very complex healthcare system that we have to do a little bit better.

DR. MICHELLE ALLEN: So I think the--

COMMISSIONER RIVERA: A lot better.

DR. MICHELLE ALLEN: the written consent is the way to go. The same way we get written consent with procedures and tests that if you are going to do a urine toxicology that has specific risks, as well as benefits, that we are open to implementing a written consent process.

COMMISSIONER LEVIN: Does Health and Hospitals differentiate between marijuana or other illicit substances when a toxicology report is

retuned in terms of whether, as a mandated reporter, people would make a referral to SCR?

DR. MICHELLE ALLEN: So, as you probably know, one of the most deleterious substances in pregnancy is alcohol.

COMMISSIONER LEVIN: Right.

DR. MICHELLE ALLEN: which is legal. In the literature is very clear that alcohol is the leading cause of mental retardation among children--

COMMISSIONER LEVIN: Uh-hm.

DR. MICHELLE ALLEN: nicotine and cigarettes actually impairs the growth of the fetus and oxygenation of the fetus. So from a medical perspective, whether it is legal or illegal, we would have the same intervention. We want to know. We are actually working with our behavioral health team to make sure-- in order to make the a urine drug testing more objective than subjective, the best thing to do before test screening. So we worked with behavioral health team, with the appropriate screening tools--

COMMISSIONER LEVIN: Right.

DR. MICHELLE ALLEN: If someone is using alcohol, if someone is using nicotine, and their

interventions we can provide for that. Nicotine is the patch. Alcoholics anonymous is the best we have. And from my perspective and our perspective, whether a drug is legal or illegal, if it has impact on parenting, if it has impact on the growing fetus, then we treat it all the same. Yes.

COMMISSIONER LEVIN: Okay. So, well, yes and no. I mean, the-- I can't-- there are plenty of obstetricians in our country that would, off the record, recommend to expected mothers or say to expected mothers, glass of water here or there is okay. I mean, I don't want to get involved in Ms. entire debate right now here and now, but it's not unheard of in our country that an obstetrician would say off the record to an expected mother you can have a glass of wine maybe two or three times a week. Now, that doesn't show up on a urinalysis test, probably. Not, you know, more than 10 hours later. But, if someone were to smoke marijuana, that would show up, you know, three weeks later on a urinalysis test. And, but in any event, we would nev-- it's not as if we would say-- It's not as if we would make a referral for casual-- for a casual glass of wine with an expectant mother whereas now it's an

indicator if somebody comes out with a positive test, urine test for marijuana, even if it could've been three weeks later and it could've been the result of just as casually used as the class of wine.

DR. MICHELLE ALLEN: So, as was stated earlier, single urine positive test does not relate to neglect, parental neglect. So there are many other confounding factors that need to be considered.

COMMISSIONER LEVIN: But we've heard from attorneys numerous times and this article shows a specific example where a single test, positive test, did result in a call to SCR. And I don't think we could say with confidence that absent other risk factors that a positive urinalysis test for marijuana does not trigger in SCR call in some instances. We don't know how many. We have no idea. We hear anecdotally from people who have experienced it or from attorneys. You know, I don't think that they're misrepresenting the truth, but since we don't-- since we're kind of-- we don't have clear data as to how we're tracking this either from Health and Hospitals or from ACS or from OCFS. It's hard for us to really get a better, clearer picture than just the

anecdotal responses that we are getting from people who have been impacted.

DR. MICHELLE ALLEN: So, I agree with you and would be happy to continue this discussion and be open to any suggestions.

COMMISSIONER LEVIN: Have we been coordinating with legal services providers? This is a question for either ACS or Health and Hospitals that often are representing clients in child welfare cases, CFR or Bronx [inaudible 01:08:09] defenders about how policies are being implemented in practice?

COMMISSIONER HANSELL: Yeah. I mean, we meet on a very regular basis with the providers that represent both parents and children and Family Court. As you know under-- in New York law and practice, both parents and children are entitled to representation and Family Court. And there are institutional providers that represent parents and children separately. Then, yes. We meet with them on a regular basis. We discuss issues that they think are systemic or representative of issues that they have concerns with that a policy level. We tried to work those through. We tried to address them as best we can. And then they also bring to us

individual cases. Obviously, we litigate individual cases, but they also will often bring to us individual cases where they think that our practice has not been consistent with policy and they ask us to look at those. So, yes. We do that on a regular basis.

CHAIRPERSON LEVIN: And so there's been a-- They've brought ACS's attention to the fact that there are people-- there are cases where it seems as if that was the sole indicator. Is that-- I mean, is that-- Have they brought that to your attention--

COMMISSIONER HANSELL: We--

CHAIRPERSON LEVIN: as a kind of--

COMMISSIONER HANSELL: We certainly--

CHAIRPERSON LEVIN: systemic issue?

COMMISSIONER HANSELL: Yeah. We certainly have had conversation about that with them. Yes.

CHAIRPERSON LEVIN: Okay. Back to Health and Hospitals policy, Dr. Allen. The article speaks to the policy of 2014 that outlines the criteria as you indicated. I don't need to go over that again. And but it says here general-- quote, generally speaking, a list like this would perpetuate stigma and selective screening-- Sorry. Generally

speaking, a list like this would perpetuate stigma and selective screening is not recommended in most contexts says ACOG's (sic) Dr. Turplin (sp?). So is there-- Are we taking issue with that characterization? Do we think that it is-- but it does not perpetuate stigma or could not be that-- the Health and Hospitals guidelines are the appropriate guidelines or are they be revisited now, especially, you know, it's been five years now since it has gone into of fact and whether that is worth revisiting?

DR. MICHELLE ALLEN: Absolutely worth revisiting. And we are constantly review our policies and procedures and recommendations.

CHAIRPERSON LEVIN: And is there anything in particular that you think is an issue that may be open for, specifically within the guidelines that are open for revisiting? Are there other jurisdictions that we can learn from elsewhere in the country that take a different approach to testing?

DR. MICHELLE ALLEN: When you say other jurisdictions, you mean other states?

CHAIRPERSON LEVIN: Other states. Other cities?

DR. MICHELLE ALLEN: So I would not want to follow--

CHAIRPERSON LEVIN: Public hospital systems?

DR. MICHELLE ALLEN: There are states that actually are incarcerating women based on drug testing or screening. Totally open to learning.

CHAIRPERSON LEVIN: Uh-hm.

DR. MICHELLE ALLEN: As I said before. Totally open to improvements. We need to constant review of our policies and procedures. Are they pertinent to the particular date and time into the circumstances and other extraneous factors? External factors.

CHAIRPERSON LEVIN: I have one last question and then I'm going to allow my colleagues to ask questions and I will have to come back at the end, but is there any research that we know of in any medical journals that make a correlation between marijuana use or casual marijuana use and adverse impacts on a fetus like the ones that you mentioned for alcohol and nicotine?

DR. MICHELLE ALLEN: [inaudible 01:12:12]

CHAIRPERSON LEVIN: Or cocaine or heroin or means which are, obviously, pretty demonstrable.

DR. MICHELLE ALLEN: So, I think we-- We're very early in marijuana where it is actually legal in a few states, so we're--

CHAIRPERSON LEVIN: Uh-hm.

DR. MICHELLE ALLEN: really hampered to do the randomize prospect of controlled studies.

CHAIRPERSON LEVIN: Right.

DR. MICHELLE ALLEN: So, most of what we are seeing in the literature is anecdotal and, having done a review of the literature recently, is thought to be of poor quality so far. Not very really rigorous.

CHAIRPERSON LEVIN: Right. Ethical issues around double-blind studies, I imagine.

DR. MICHELLE ALLEN: Yeah. So, there's nothing in the literature that says that there is any significant sequelae--

CHAIRPERSON LEVIN: Uh-hm.

DR. MICHELLE ALLEN: for marijuana utilization during pregnancy. A lot more research needs to be done.

CHAIRPERSON LEVIN: Okay. I'll turn it over to my colleagues for questions. First question, Council member Richards.

COUNCIL MEMBER RICHARDS: Thank you, Chairs. Great hearing. So on 2018, how many removals of newborn children were executed by ACS due to a positive toxicology for marijuana?

COMMISSIONER HANSELL: Well, none would have been executed solely for a positive toxicology for marijuana. We can-- I can--

COUNCIL MEMBER RICHARDS: And if you can also go through the last five years and also to have a breakdown by borough?

COMMISSIONER HANSELL: I don't have that information really. We are happy to provide that information to you and to the Council.

COUNCIL MEMBER RICHARDS: So, you do have-- Okay. So--

COMMISSIONER HANSELL: We have informa--

COUNCIL MEMBER RICHARDS: you don't have any of this information or?

COMMISSIONER HANSELL: We have information on number of removals and we certainly can do that geographically. I am actually looking for a data--

COUNCIL MEMBER RICHARDS: Okay. Do you have the--

COMMISSIONER HANSELL: Okay. I apologize. We don't have it by borough. But we could--

COUNCIL MEMBER RICHARDS: Okay. Let's move away from borough. Can you just give specific numbers? So how many removals of newborn children were executed by ACS due to a positive toxicology for marijuana?

COMMISSIONER HANSELL: Well, as I said, none.

COUNCIL MEMBER RICHARDS: All right.

COMMISSIONER HANSELL: None would've been executed solely for--

COUNCIL MEMBER RICHARDS: All right. So can you give me numbers on marijuana plus whatever else?

COMMISSIONER HANSELL: We don't have currently-- Unfortunately, as I said in my testimony, Council member, we don't have information by specific drug type because the state system, until

three months ago, didn't even allow that information to be entered into the system. It now does, but the state has only given us guidance so far that doesn't suggest they wanted to be used to determine the type of allegation by specific drug. So that is a conversation were going to have to continue to have with the state. We have just gotten that guidance, literally, just in the lock week or two.

COUNCIL MEMBER RICHARDS: So, just take me through that again. I'm sorry.

COMMISSIONER HANSELL: Sure. Sure. So, until-- Let me back up. We are required by the state to use their system of record, which is called connection. So, all of the data we collect-- First of all, all of the information from the report that comes into the state central registry in the first place that gets referred to us is referred through that system. So that system determines what information we get which is about the allegation that was--

COUNCIL MEMBER RICHARDS: All right.

COMMISSIONER HANSELL: the basis for the report. And then, as we do our investigation, we are required to enter any information that we collect in

the course of that investigation that may be much more specific than within the original report, we are required to enter that system, into the connection system. And that is the sole, you know, form of--

COUNCIL MEMBER RICHARDS: Okay. So I'm hearing a lot of state, state, state. So, the state of mind I want to get into is what prevents ACS from-- So state law prevents you from collecting data on marijuana? Is that what I'm s-- So, because there is a database that doesn't have a drop box that would collect this specific information, you have never collected, there's no notes, there's no information on marijuana connected to the website or maybe I'm just not reading this for hearing this correctly.

COMMISSIONER HANSELL: No. That's correct. We are required to use that system to collect information. That system, however, does, as of January, have a drop-down box that will allow the collection of some information by individual drug type that didn't--

COUNCIL MEMBER RICHARDS: Oka.

COMMISSIONER HANSELL: exist until three months ago.

COUNCIL MEMBER RICHARDS: So, as of January, can you give me the numbers?

COMMISSIONER HANSELL: No. Because the state-- We are still in discussion with the state about how they want us to use that new functionality.

COUNCIL MEMBER RICHARDS: [laughter]

COMMISSIONER HANSELL: But part of that discussion we will have with the state is--

COUNCIL MEMBER RICHARDS: Wait. So hold on. So you said three months ago they, this specific drop box, whatever this is allows you to enter this data, correct?

COMMISSIONER HANSELL: The functionality was added to the system.

COUNCIL MEMBER RICHARDS: So the functionality was added which means--

COMMISSIONER HANSELL: Right.

COUNCIL MEMBER RICHARDS: that you could now check the specific drug type or-- I'm just trying to understand. What's changed in three months?

COMMISSIONER HANSELL: Let me let Associate Commissioner Marks--

COUNCIL MEMBER RICHARDS: Okay.

COMMISSIONER HANSELL: speak since her-- It's her staff that really--

COUNCIL MEMBER RICHARDS: [interposing] I had a long night last night, so forgive me if--

COMMISSIONER HANSELL: It's very common.

COUNCIL MEMBER RICHARDS: I'm not understanding and comprehending this as much as I should, but--

ASSISTANT COMMISSIONER MARKS: Sorry. I think the drop down, the state's intention is for us to determine use versus allegations of marijuana and that's some of the clarity that we are still seeking. Is that, you know, the allegation that is called into the state central registry or is that what we actually discover when we go out to do the investigation. So that is the clarity that we are still seeking. And, you know, we don't want to enter inappropriate data. So we are waiting for clarification on that.

COUNCIL MEMBER RICHARDS: So nowhere in your records right now to you have records on specific marijuana allegations?

ASSISTANT COMMISSIONER MARKS: Not in an aggregated way that we can give you that information.

COUNCIL MEMBER RICHARDS: But you do have that information.

ASSISTANT COMMISSIONER MARKS: We don't have it-- So when the report gets called in, there is a narrative field and the narrative field is where the allegations get entered. And so that's like a paragraph of what the reporter told the person answering the phone at the state central registry. So it's not in a way that we can report it out at this time.

COUNCIL MEMBER RICHARDS: So let me ask you this. And I'm just going to go back to your testimony, Mr. Commissioner. You spoke of as you probably know, approximately 50 infants in New York City die every year because of unsafe sleep practices, most often that involves bed sharing by parents and infants and, tragically, that often occurs when a parent is under the influence of alcohol or drugs. Can you just elaborate a little further on that statement?

COMMISSIONER HANSELL: Yeah. Let me begin and then I'll let Associate Commissioner Marks speak to that. But, so--

COUNCIL MEMBER RICHARDS: And does that conclusive data or-- I mean, where you--

COMMISSIONER HANSELL: It is--

COUNCIL MEMBER RICHARDS: These are substantiate. How many of these were related to marijuana?

COMMISSIONER HANSELL: Yeah. It is not our data because the investigation of fatal-- those fatalities like other child fatalities are actually done by the Department of Health and Mental Hygiene, not by ACS.

COUNCIL MEMBER RICHARDS: But you cited this data in your testimony. So, can you-- If you're going to cite this and you're talking about marijuana today, I feel it should be a little bit more specific. So, would you say marijuana has aided-- is a part of this or?

ASSOCIATE COMMISSIONER MARKS: I would say in some cases with infant fatalities, marijuana did play a role--

COUNCIL MEMBER RICHARDS: [interposing] Is that conclu-- Is that factual or always speaking--

ASSOCIATE COMMISSIONER MARKS: Um--

COUNCIL MEMBER RICHARDS: hypothetically right now?

ASSOCIATE COMMISSIONER MARKS: I don't have a number right now, but--

COUNCIL MEMBER RICHARDS: Okay.

ASSOCIATE COMMISSIONER MARKS: having reviewed cases from the medical examiner, those were some of the findings that may have.

COUNCIL MEMBER RICHARDS: They may have or they have?

ASSOCIATE COMMISSIONER MARKS: They have. I don't have a number exactly, though.

COUNCIL MEMBER RICHARDS: Okay. So we would appreciate those specific numbers, but last I checked, I had a bill that was very based on what happened in Sweden and part of the reason many infants die in New York City based on suffocation is due to not having a bed. A crib. And I would hope that the Department of Health hears this conversation them would support the bill so we can move it or we move it so that we can ensure babies have cribs in New York City. That is the number one reason. What precludes you from setting up your own database with this information?

ASSOCIATE COMMISSIONER MARKS: Yeah. The state requires us by law to use the database so that there is one system of record for--

COUNCIL MEMBER RICHARDS: [interposing] So, state law would prevent you from collecting this data somewhere else?

ASSOCIATE COMMISSIONER MARKS: Well--

COUNCIL MEMBER RICHARDS: Is that true?

ASSOCIATE COMMISSIONER MARKS: State law asks us to use that system as our system of record.

COUNCIL MEMBER RICHARDS: [interposing] Okay. So I know state law asks you to and that could be one record, but does that prevent you from collecting data for New York City separately from the states database?

ASSOCIATE COMMISSIONER MARKS: So, it's something we can look into, I think, and have a conversation--

COUNCIL MEMBER RICHARDS: So, the question is yes or no. Does state law preclude us from collecting this data outside of the state's database?

COMMISSIONER HANSELL: My understanding and we will confirm this to you, is that that state

does require that any information we collect be maintained solely in their system so they have a complete record in the investigation that we do so that they would not allow us to collect that data or use that data in the system outside of their system.

COUNCIL MEMBER RICHARDS: Right. But I'm not saying a system or creating a new system. What I'm saying is cut ACS on its own, New York City, collect this information, compile this information in a way that the Council could see it?

COMMISSIONER HANSELL: Well--

COUNCIL MEMBER RICHARDS: I'm not saying create a new database.

COMMISSIONER HANSELL: We can analyze and report in the data-- to the Council data from the state system as the state allows us to do it and we are hoping, based on discussions we will now have with the state, that we can use the new functionality that they have just added to the system to do that. But we need to discuss with them what the Council's interested in and see if the state is willing to allow us to collect and analyze the data in the form that you want.

COUNCIL MEMBER RICHARDS: Okay. I'm going to begin to wrap up because I know my other colleagues of questions and this is not my hearing. Can you just go through-- So, Ms. Kennedy, this story, can you-- So, her children tested negative for marijuana, by ACS made her go to court and she was mandated to an outpatient rehab program three days a week or risk losing her three children. Can you speak to this specific case?

COMMISSIONER HANSELL: Well, I'm actually not familiar with it, but even if I were, we are prohibited by law from talking about specific cases.

COUNCIL MEMBER RICHARDS: Okay. But are there any case-- So, does ACS mandate outpatient rehab programs for parents? For mothers?

COMMISSIONER HANSELL: In some situations. Yes.

COUNCIL MEMBER RICHARDS: Has that been done solely bases on marijuana?

ASSOCIATE COMMISSIONER MARKS: No.

COMMISSIONER HANSELL: It has not.

COUNCIL MEMBER RICHARDS: So what was it based on?

COMMISSIONER HANSELL: Our policies-- It would be based upon a determination that marijuana use or any other substance created a safety risk to a child that required some kind of intervention and, presumably, in that case, the intervention would have been outpatient rehabilitation treatment.

ASSOCIATE COMMISSIONER MARKS: I also want to clarify that ACS doesn't mandate. It would be the court--

COMMISSIONER HANSELL: That's correct.

ASSOCIATE COMMISSIONER MARKS: mandating the treatment.

COUNCIL MEMBER RICHARDS: And ACS would've recorded-- reported that to the court?

ASSOCIATE COMMISSIONER MARKS: Right.

COUNCIL MEMBER RICHARDS: So ACS would've reported she uses-- she used marijuana in this specific case--

ASSOCIATE COMMISSIONER MARKS: So it--

COUNCIL MEMBER RICHARDS: to the courts.

ASSOCIATE COMMISSIONER MARKS: So, as the Commissioner stated, it wouldn't just be the use of marijuana. It would be the use of any substance

and the impact that that substance had on child safety.

COUNCIL MEMBER RICHARDS: All righty. Okay. I look forward to certainly hearing more on this. Mr. Chair, I don't see why we should not proceed with these bills. I believe that ACS could give up this information and compile it in a way outside of the state's database and I guess we could debate this today, but-- and also, just lastly, do you believe there are disparities in this specific area? You cited it and your testimony around marijuana and testing. So, when we get this data eventually, will it show what I believe it will show? I'm going to ask do the lawyers rule. Ask a question you know the answer to. While the data predominantly show that majority of cases that ACS, whether substantiated or not, investigates are centered in communities of color?

COMMISSIONER HANSELL: I can't forecast what the specific analysis will show. Again say, as I said in my testimony, that we know that there've been racial disparities both in the criminality of marijuana use--

COUNCIL MEMBER RICHARDS: Uh-hm.

COMMISSIONER HANSELL: and there have also been racial disparities historically in child welfare involvement.

COUNCIL MEMBER RICHARDS: Yep. Okay. All righty. I know the answer to the question, but all I thank you for the work that you are specifically doing in performing ACS and I hope that, after this hearing, that we will specifically start to address what we know are the disparities in the way, especially black mothers are handled. Black and brown mothers are handled in the general welfare system. So thank you. Council member Adams for questions.

COUNCIL MEMBER ADAMS: Thank you, Mr. Chair. Thank you, Madam Chair for this important hearing today. Welcome and thank you so much for your testimony today. My issue, as I've listened to the testimony and the questions from my colleagues, my issue is the systemic criminalization of women of color pertaining to the matter at hand today. And as I've listened to the details of the Kennedy case, which you don't seem to be familiar with, but several of us are extremely disturbed by that, it becomes very, very clear that there is a horrible issue with

the federal government taking children away from parents who have provided a home for their children, for parent who have prepared a home for their newborns, for parents that have prepared to love their children. And so, my questions is, when we look at the cases of marijuana versus alcohol, how are those cases treated differently in preparing the mother for the consequences of use by each of those substances?

ASSOCIATE COMMISSIONER MARKS: Are you asking either one of us or--

COUNCIL MEMBER ADAMS: Anyone who can answer.

DR. MICHELLE ALLEN: That's a very important question and thank you for asking that question. So when we get a history from a mother and we are talking about substance use, the question is broad. Do you use any substances and what do you use? And very often we get polysubstance use. So, marijuana with alcohol, marijuana with cigarettes. And I take your point and appreciate your point of what the federal government is doing in terms of separating children from intact families and healthy families. I think, in terms of marijuana, it's an

education. We don't have the literature all in. What are the side effects or if [inaudible 01:28:52] the marijuana, as I said earlier, we have not had good studies at all. So it really is about education and as I've said from the maternal side, we do not report to anybody anything. It's totally about a conversation in education.

COUNCIL MEMBER ADAMS: Okay. I appreciate the answer. I think my question pertains more to the information that is provided to the mother. Are you informing the mother of the consequences of her disclosure?

DR. MICHELLE ALLEN: Yes.

COUNCIL MEMBER ADAMS: So, as far as the differences between alcohol and marijuana, again, what is the difference in treatment of a mother that has disclosed alcohol use--

DR. MICHELLE ALLEN: So the--

COUNCIL MEMBER ADAMS: verses marijuana use?

DR. MICHELLE ALLEN: sequelae are large. So, the conversation around alcohol has to do with intrauterine growth restriction, mental retardation, fetal alcohol syndrome. That is a very different

conversation with marijuana that we don't know the sequelae that is not as deleterious as alcohol, per se, as I said earlier. It's the most harmful drug to a developing fetus. And that would be the indication. If there is a woman who is drinking alcohol, that's very straightforward. The literature is replete. It is not replete with marijuana you can't say with clarity or with conviction that there is going to be a deleterious impact.

COUNCIL MEMBER ADAMS: So, I guess for me, as a mother and grandmother, and looking at this mother, the most disheartening part of the responses have been-- in hearing the responses for me have been the for alcohol users, because it is legal, it's okay. Firm marijuana users, and we really don't even have a measuring stick or a bar. The tool of measurement to even qualify or quantify punishment for a mother that we are absolutely tearing families apart needlessly and that's not that I am blaming you because I understand that you value your work. But I just want to make sure that I am heard. The devaluization of single black women when it comes to their children and the protection of their children-- and I listened to my colleague present a question

which I thought was very interesting. And that had to do with the care of a newborn, all right? And I thought back to the care of my own newborn and cosleeping with my newborn for the very first night of her life over 30 something years ago and the fact a non-substance abuser, that's okay, but the perception of a substance abuser-- we are now going to criminalize a single mother for doing what I did as a non-substance abuser. Very, very typical behavior for every new parent to share with their newborn. So I'm very disturbed by your testimony today. I appreciate it, but I'm very disturbed by your testimony today and I really, really hope that we do better, number one, with our reporting, number two, with our sensitivity, and I look forward to passing the legislation that my colleagues have so brilliantly put forth. So thank you very much.

CHAIRPERSON LEVIN: Thank you, Council member Adams. Council member Reynoso for questions?

COUNCIL MEMBER REYNOSO: That's going to be tough to follow. I really appreciate the testimony. Hearing that. I just want to be clear, I had my son in a Health and Hospitals facility in Woodhull Hospital. I thought it would be valuable

that the facilities that I have entrusted my community to go to is something that I can go to. I care deeply about Woodhull Hospital and I think they did a great job with my family and hearing the stories is very-- it's troubling for me, but I want to ask some technical questions. I'm very concerned about your consent policy. In 20-- I want to say 2013, over 700,000 young men of color, mostly young men of color, were stopped and frisked in the city of New Yorkers which was found to be unconstitutional and that officers arrested about 60,000 young men of color there is something that they called voluntary consent. The voluntary consent made it so that these officers asked mostly young men of color to go inside their pockets and empty them. As soon as the individual when in their pockets and started taking things out, they are voluntary consenting to the search. They had no idea that they were doing that. They were incriminating themselves because of the lack of information. The cops, for years after that, said we are letting them know about their right. We are letting them know that they have a right to refuse this search. We are letting them know about what this means for them. The problem is the power

dynamic. When an officer tells you to take stuff on your pocket, you take things out of your pocket and a fear of escalation. Right? Now, somebody in a white coat-- I'm thinking about when I was at the hospital and how differential I was to any advice given to me by any doctor. The doctor could told me, Antonio, you need to take three shots right now and I want to put my arm up glad. Not knowing what it was. I trust the doctors. So these doctors are telling these mothers, hey, would you consent to this drug test? All right? Not knowing the harm that they could impart on themselves legally, the possibility of separation from their child. All these things happening and that you are asking that this consent be verified. This consent that could damage the life of this family be something that is not signed off by the person that is consenting and that it be documented in writing by the person asking for it, the doctor. And then making it so we as a city Council can ask for information related to demographics of who is consenting to these things because of a state issue that you guys have related to reporting. It's just so much what I consider institutional racism. That's what it is. You

institutionally are putting us in a position where we can even help these mothers. You are institutionally allowing for a process that is very questionable when it comes to consent to dictate the lives of these women and their children. It's very concerning. I think that your objections are, again, are hiding behind this institutional racism and I'm not going to qualify it. So I am going to push for my legislation to be had and force the health and hospitals to figure out a way that it can document the demographics of who is being effective outside of the system that exists by which the state is the only per-- we have no authority. We can't see it because the state controls it. Well, I want you to do it twice then. I want you to put on one piece of paper to the state we just have those black woman tested. And I want you to check same box in a different piece of paper that is going to come to us. That's what I'm going to ask for you to do. And I'm not-- I don't have any questions. What I'm hearing today, again, as part of this institutional degradation and racism mostly against women of color, black women, and these hospitals and we should be fighting against that. Thank you.

CHAIRPERSON RIVERA: Thank you. I wanted to just add clearly we are all very passionate about this issue because we know that racism and systemic oppression is everywhere, but just so you know that we have a number of articles and data that we have reviewed that totally backs this up and we have, you know, the US national Library of medicine, national Institute of health said of the 8487 cases of women who have had live births, three percent or 244 mother newborn pairs were tested for illicit drug use and that women who are black and their newborns were 1.5 times more likely to be tested than nonblack women. So this a study and we are so, so concerned because the other issue is that, even if the report is determined to be unfounded, it stays in the statewide register for 10 years. That is a very, very long time to have something that is unsubstantiated follow you around when you are a person of color who is already disproportionately impacted by laws that were created to keep you down. So do you document when a call to the state is made in the file?

DR. MICHELLE ALLEN: That's not in the mother's file.

CHAIRPERSON RIVERA: That's not in the patient's file. You get the consent and if the--

DR. MICHELLE ALLEN: We don't--

CHAIRPERSON RIVERA: test is positive, you don't document that you made a call?

DR. MICHELLE ALLEN: We don't make calls. The obstetrician does not make a call to anybody. On the baby side, when it is documented, if the pediatrician has made a call to the state central registry, that is usually with supportive social work, that is documented in the newborns chart. As I said, no the-- the reports to the state of Central Registry of child abuse and neglect are not made by obstetricians. Not on the mother's side.

CHAIRPERSON RIVERA: So we are-- As I mentioned earlier about biased training, and your testimony, you mentioned that there is a recently launched mandatory implicit bias training for all ACS staff and the creation of an office of equity strategies and a new equity assessment that will help us implement strategies that identify and forestall potential racial and other inequities in each of our programmed areas. Does H&H have any interactions

with ACS and does ACS ever educate the staff especially considering this new training?

COMMISSIONER HANSELL: We have a great deal of interaction. Quite a bit. I don't, offhand, actually know whether we have had conversations specifically about implicit bias training or other equities strategies. I think it would be a very good idea and that is something that I think I can say on behalf of Dr. Allen and myself, we will take back and look for the opportunities to do that.

CHAIRPERSON RIVERA: Thank you.

CHAIRPERSON LEVIN: Before turning it over to Council member Grodenchik, I actually wanted to follow up on that last question. So, when I have the opportunity to go out with you, Commissioner, to the field to meet with CPS staff, who was a really great meeting recently and one of the suggestions that came from them was, while ACS staff and CPS are doing implicit bias training and they welcome the-- and they are, I think, were very happy to do it, they felt that there was not the same level of training for mandated reporters and that, at CPS, they are investigating the cases that come to them. They don't originate the cases. They have to do their

job. But that the number of calls that go into SCR are so disproportionately against women of color that, perhaps, we should be embarking on-- I mean, Health and Hospitals would be a good place to start, but perhaps we should be embarking on a broader implicit bias education with mandated reporters across the city. And that is, you know, many thousands of mandated reporters. So this would be a difficult thing, I think, to be-- present a logistical challenge, but what do we think about that idea?

COMMISSIONER HANSELL: I was, of course, there, as well, from a conversation. It was very interesting and I think very well taken. There is no question, you know, as I said in the testimony, we are obligated to report-- to investigate any report we receive, but there clearly are patterns of geographic disparity and racial disparity in that reporting. So I think in something well worth considering.

CHAIRPERSON LEVIN: Uh-hm.

COMMISSIONER HANSELL: The designation of who are considered mandatory reporters is made by state law and, actually, the requirements for

mandated reporters are also set by the state. So I think it's a conversation we can certainly initiate with the state, perhaps, along with the Council. But also in terms of specific categories of mandated reporters, including Health and Hospitals staff, there are certain things we could antic-- you know, initiate on our own.

CHAIRPERSON LEVIN: Uh-hm.

COMMISSIONER HANSELL: And so I think part of the conversation that-- in response to Chair Rivera's question that I committed that we would do is to take back with our conversation with Health and Hospitals whether there is work that we can do together around the mandated reporting that comes with health and hospitals in making sure that implicit bias another things are addressed in the training of those mandated reporters.

CHAIRPERSON LEVIN: Right. And what was so striking is this wasn't a suggestion coming from, you know, the city Council member who, you know, doesn't necessarily know what happening on the ground, but from a CPS who obviously does.

COMMISSIONER HANSELL: Absolutely.

CHAIRPERSON LEVIN: Council member Grodenchik.

COUNCIL MEMBER GRODENCHIK: Thank you, Chair Levin. Thank you, Chair Rivera. Thank you, Commission, Dr. Allen, Associate Commissioner Marks. Commissioner, do we keep statistics on how marijuana use affects parenting? Have we-- Do we have surveys or any statistics regarding that? I mean, I appreciate the testimony and the answers you've given today. I'm just wondering-- You know, from Dr. Allen's testimony, it's not something I think about every day, to be quite honest, but I do remember reading and hearing about the deleterious effects that alcohol has.

COMMISSIONER HANSELL: Uh-hm.

COUNCIL MEMBER GRODENCHIK: We all know that. But I'm just wondering, are there statistics similar to statistics kept for marijuana use?

COMMISSIONER HANSELL: Well, there is certainly research around the impact of marijuana and as Dr. Allen said, it is not yet quite very definitive. So, you know, we-- because our concern is, as I said in my testimony, our concern is about the safety and risk impact on children. As we do

that investigation, that's what we're looking for. So anything that tells us or establishes a relationship between the use of any substance, marijuana or any substance, and potential impact on parenting capacity or safety of children is the kind of thing that we want to make sure that our policies are addressing as we do our investigations.

COUNCIL MEMBER GRODENCHIK: Do you have anecdotal evidence at? I mean, you've got a lot of people in the field. I know the work that you are doing and I greatly appreciate what you have done for the agencies and see you came here to us. Do you have anecdotal evidence that you can share with us or maybe you don't want to share with us? I see the smile. I--

ASSOCIATE COMMISSIONER MARKS: I mean--

COUNCIL MEMBER GRODENCHIK: I know the dangers of anecdotes at times. So--

ASSOCIATE COMMISSIONER MARKS: Yeah. I mean, I've been doing this work a really long time so I can certainly share some anecdotes, but I want to caution against, you know, using that in a systemic way. And we look at each case and we assess each case individually and they are very--

COUNCIL MEMBER GRODENCHIK: [interposing] As you have to.

ASSOCIATE COMMISSIONER MARKS: Yeah. They are very, very nuanced decisions and sometimes, you know, marijuana use-- One example might that-- You know, a person-- And people also have different reactions to marijuana use, right? So that something else to consider. So, sometimes a parent may be using so much marijuana that they can't get up in the morning and they aren't getting their children to school on time. You know, we see that happening. We see sometimes that they spend all of their earnings on marijuana rather than on food and basic medical care. So, it's those types of assessments that we need to make on each individual case--

COUNCIL MEMBER GRODENCHIK: [interposing] Would you say--

ASSOCIATE COMMISSIONER MARKS: and it doesn't--

COUNCIL MEMBER GRODENCHIK: at that point, we would not be happy with any parent who is not getting their child to school on time, correct?

ASSOCIATE COMMISSIONER MARKS: And that, again, doesn't mean that that would cause a removal.

That would just be the impact on the child and then we would assess more carefully about what services we can provide to mitigate that.

COUNCIL MEMBER GRODENCHIK: Okay.

ASSOCIATE COMMISSIONER MARKS: You know, we have a big continuum of preventive services and, you know, when we see that sort of impact, that is always our first route.

COUNCIL MEMBER GRODENCHIK: Okay. Thank you very much. I waited a long time for that, but I do appreciate the Chairs holding this hearing today and I appreciate you being here today and I've got to go get ready for my hearing. So, thank you all. Thank you, Chairs.

CHAIRPERSON LEVIN: Thank you very much, Council member Grodenchik. So, we have a few more questions to get through and I realize we have had a lot of questions for Dr. Allen. I just have--

CHAIRPERSON RIVERA: Thank you.

CHAIRPERSON LEVIN: I just want a little bit of clarification. When you said that they obstetricians are not mandated reporters or they--

DR. MICHELLE ALLEN: No. They--

CHAIRPERSON LEVIN: They're not making the calls into the SCR?

DR. MICHELLE ALLEN: We are mandated reporters, but if we have a mother who is using drugs--

CHAIRPERSON LEVIN: Uh-hm.

DR. MICHELLE ALLEN: or we get a positive urine toxicology, that does not result in a call to the states central registry. We don't consider fetuses children.

DR. MICHELLE ALLEN: And the state registration is-- The state central registry of child abuse and neglect, from my understanding, has to do with child abuse and--

CHAIRPERSON LEVIN: So in an instance-- And I don't believe Ms. Kennedy delivered at a Health and Hospitals facility, but in her case, the children did not have a positive toxicology and she had told her physician, her obstetrician, that she use this for medical purposes. So, in that instance, I mean, I realize it's not Health and Hospitals, but how could the call have then got into SCR is the child-- it wouldn't have been the pediatrician, I assume, because they didn't have a positive toxicology.

DR. MICHELLE ALLEN: So, I cannot explain that. I don't know that case. But it is possible that the pediatrician did: based on the maternal drug result, which is in the chart.

CHAIRPERSON LEVI: It's in the children's chart?

DR. MICHELLE ALLEN: At the time of delivery, we transfer information about the mother that is pertinent for the pediatrician to be able to assess the child. So we-- blood count, gonorrhea, syphilis, all the test that we do during the prenatal period--

CHAIRPERSON LEVIN: Right.

DR. MICHELLE ALLEN: hepatitis status--

CHAIRPERSON LEVIN: But those are all--

DR. MICHELLE ALLEN: HIV status--

CHAIRPERSON LEVIN: You know, those are all conditions that can be passed to the fetus that are, you know, obviously--

DR. MICHELLE ALLEN: Yeah.

CHAIRPERSON LEVIN: present a significant risk to the fetus. Or to the newborn. I guess, my question is something happened there and I'm wondering whether this is an outlier or whether

this is-- And I think, I mean, that's the big question, I think. Is this an outlier, that case or is that-- or is there something-- is that indicative of the broader end?

DR. MICHELLE ALLEN: I can speak from my experience at Health and hospitals that that is an outlier if it happened Health and Hospitals. They obstetricians do not call into SCR based on a maternal talk screen.

CHAIRPERSON RIVERA: Can I-- Then I have a copy of the policy here that I know is hard to get your hands on if you're just a normal public person, but it says the director of social work services at each facility is responsible for ensuring the appropriate provision and/or referral for counseling is provided to the pregnant and postpartum woman and any report made to the central-- to state central registry. Is that the director for social work services that kind of leads and manages this reporting?

DR. MICHELLE ALLEN: We just--

CHAIRPERSON RIVERA: [inaudible 01:49:59]

DR. MICHELLE ALLEN: social work evaluation of the family. The social worker would be the one who would recommend a call to the SCR.

CHAIRPERSON RIVERA: Okay. So, I wasn't trying to give you an answer. I was just asking whether, you know, the people that are obligated to the report versus the person who makes sure that they escalates any sort of note that they feel is serious. Registering to get a clear answer as to how the process goes. I didn't want to take us from beginning to end because we have some attorneys in some defenders and people here with personal experiences that we really want to get on the record as soon as possible. So I wasn't going to ask you to take us from step-by-step because we are a little bit unclear as to the details here, but I'm trying to, at least, pull information from your very own policy to understand who makes the call and how we can, you know, hold some people accountable.

DR. MICHELLE ALLEN: Can I get back to you on that?

CHAIRPERSON RIVERA: Sure. Thank you.

CHAIRPERSON LEVIN: Okay. So, I'm going to-- As Chair Rivera mentioned, I do have a

number of people that would like to testify and have been waiting for a while. And so we appreciate everybody's patience. I do want to go through a few more questions for ACS if that's okay. So, if these require a short answer, then that's sufficient. Can ACS determine a case is unfounded and close the case without an investigation if the sole reason for the report of neglect as a positive drug screening? Or do they have to do a full investigation?

COMMISSIONER HANSELL: If the state refers the case to us, we are required to do an investigation.

CHAIRPERSON LEVIN: Can the case be closed after a single visit of the only reason for the report was marijuana use or drug use and it was determined to that, that first visit, it does not appear that there are any other risk factors connect-- or is that-- or is it going to take a full 60 days or somewhere around there?

ASSISTANT COMMISSIONER MARKS: No. It definitely does not have to be a full 60 days. It would require a home visit and an assessment of all the children and the alleged subjects and then calls to the source and other collaterals, but we can

certainly close a case way before 60 days and we have done that and do that pretty routinely.

CHAIRPERSON LEVIN: Okay. Do we have a clear picture of how many cases are called in where the soul risk factor is marijuana use?

COMMISSIONER HANSELL: No. We don't. For the reasons that we were talking about earlier that the state system has allowed us until recently and we hope prospectively at well, hasn't allowed us to disaggregate by individual type of substance. So, no. We have not been able to do that.

CHAIRPERSON LEVIN: Or-- Okay. So, then exclusively for substance use, but not-- but without disaggregating for type of substance?

COMMISSIONER HANSELL: So--

CHAIRPERSON LEVIN: Exclusively-- So, not with other risk factors?

COMMISSIONER HANSELL: Okay. So--

ASSISTANT COMMISSIONER MARK: In combination--

COMMISSIONER HANSELL: Yes. We only have in combination.

CHAIRPERSON LEVIN: In combination.

COMMISSIONER HANSELL: So, about 25 percent--

CHAIRPERSON LEVIN: With comb-- in combination.

COMMISSIONER HANSELL: Involved allegations of substance use either with or without--

CHAIRPERSON LEVIN: Right.

COMMISSIONER HANSELL: further allegations.

CHAIRPERSON LEVIN: Right. If it's possible to break that down further and disaggregate that and I maybe will-- Am offering no work with OCFS to try-- It would be good for us to be able to know-- Again, this is all for informational purposes so that we are getting a clear picture of how policies are impacting lives.

COMMISSIONER HANSELL: Understood. And we are happy to work with you on that. And I hope I was clear in my comments on the two bills that our concerns are not philosophical at all. They are purely practical.

CHAIRPERSON LEVIN: Yes. Understood. And I'm confident that we can work together to get legislation that can gain the administration's

support. What is the procedure for CPS to determine marijuana use in a-- You know, after the children are born?

ASSISTANT COMMISSIONER MARKS: I mean, can you just clarify what you mean by determine? Would that be--

CHAIRPERSON LEVIN: [interposing] Yeah. I mean, if there's a-- an allegation goes into the SCR of marijuana use, that the CPS goes how are they determining whether the parent is using marijuana?

ASSISTANT COMMISSIONER MARKS: Right. So, you know, just want to clarify that we are doing more than determining just to use. We are determining if they use has impact and if there are safety issues. Right? And in order to determine that, we have to interview everyone in the home and we try to do that separately whenever possible. We would also interview collateral contacts. So, pediatricians, schools when applicable, neighbors who may be able to tell us what's going on in the home, and then, if we do have some suspicion of drug use, we will turn to our CASAC, our credentialed alcohol substance abuse counselors so that they can help us

do an assessment to see if the parent can tell us a little bit more about their potential use and the impact on the child.

CHAIRPERSON LEVIN: Okay. So, it's-- the CPS isn't doing that on their own. They involve the CASAC on that?

ASSISTANT COMMISSIONER MARK: Definitely not. And all through this process, and there is a supervisor who is reviewing the steps that are taken and, and many case, with drug use there are managers who reviewed these cases. So they are definitely not doing that on their own.

CHAIRPERSON LEVIN: Right. Right. I think we're-- I think in-- For the purposes of this hearing, I don't think that we're in anyway insinuating that any particular staff is unqualified or unable were doing mistakes. Were more concerned, I think, with-- at least I can speak for myself-- kind of the systemic structural issues here. Not necessarily an appropriate actions by any particular staff or staff level. So, yeah. That's certainly my concern is kind of the broader structural practices in place and procedures. Going back to the case that we have been talking about, does ACS and, for that

matter-- and we've talked about this, but I'm not quite sure that I have a clear picture. Does ACS or Health and Hospitals personnel fully tell a person when they disclose something like marijuana use of the potential impacts that that could have on their case moving forward?

DR. MICHELLE ALLEN: So, from the obstetrical side, as I said earlier, there is disclosure about the positive test. If the child is-- It's not so much the mothers test, so I--

CHAIRPERSON LEVIN: Uh-hm.

DR. MICHELLE ALLEN: cannot speak to the Kennedy case that you are referring to.

CHAIRPERSON LEVIN: Sure.

DR. MICHELLE ALLEN: I'm not familiar with it at all.

CHAIRPERSON LEVIN: Uh-huh.

DR. MICHELLE ALLEN: On the Health and Hospitals, the disclosures my conversation with you if you are my patient is our objective is to have a full term pregnancy with the appropriate grown fetus without complication and that you and the child are drug-free at the time of delivery. The drug testing during the course of the pregnancy is not about

reporting and there should be no sequelae of getting a positive test of getting the positive test during the pregnancy. However, if you are born, if the child is born-- If your child is born with a positive toxicology, there is a risk that, based on the assessment of the pediatrician and social worker at that time, that that will be called into the state central registry.

CHAIRPERSON LEVIN: Uh-hm.

DR. MICHELLE ALLEN: So, it is all dependent on the newborns toxicology--

CHAIRPERSON LEVIN: Right.

DR. MICHELLE ALLEN: not the maternal toxicology.

CHAIRPERSON LEVIN: And marijuana, do we have any clear picture from a medical perspective how much marijuana is required to cross the placenta to show up in a toxicology report for a newborn?

DR. MICHELLE ALLEN: Yeah. It's like actually-- I did have that. I don't have it at my fingertips now.

CHAIRPERSON LEVIN: Okay. Okay. So, in that sense, it wouldn't-- I mean, there's no HIPPA issue there in terms of if a mother discloses

that she is used marijuana while pregnant, that that is not-- Does she have HIPPA rights that--

DR. MICHELLE ALLEN: Say that again.

CHAIRPERSON LEVIN: Does she have-- Sorry. Does she have HIPPA right there--

DR. MICHELLE ALLEN: In terms of her child?

CHAIRPERSON LEVIN: Well, in terms of her-- If's the user--

DR. MICHELLE ALLEN: Right.

CHAIRPERSON LEVIN: and her physician, is her physician then prohibited from sharing that information because of her rights under privacy?

DR. MICHELLE ALLEN: With whom? The pediatrician?

CHAIRPERSON LEVIN: With any. With pediatrician, with SCR-- I--

DR. MICHELLE ALLEN: Uh--

CHAIRPERSON LEVIN: I know you're saying that it's not being called over to SAR, but clearly it happens at some point somewhere.

DR. MICHELLE ALLEN: So, there is no HIPPA issue between the pregnant mother's medical record and sharing that with the pediatrician.

CHAIRPERSON LEVIN: Okay.

DR. MICHELLE ALLEN: That is, in fact, expected in its proper care.

CHAIRPERSON LEVIN: But with any-- With SCR, there's--

DR. MICHELLE ALLEN: So, with SCR, that has to do with being a mandated reporter for child abuse and neglect and when you are an obstetrician taking care of a mother with a fetus, the fetus is not a child.

CHAIRPERSON LEVIN: Right. Okay.

DR. MICHELLE ALLEN: So far.

CHAIRPERSON LEVIN: Right. I mean, it's an interesting question becomes, is that that happens-- I mean, it's a hypothetical, but if that were to happen, then it is that mother's HIPPA rights being violated? Or if the call goes into SCR based on-- I'm sorry. This may be splitting hairs here or-- but I just-- it's a question to ponder. We don't have to go further.

DR. MICHELLE ALLEN: [inaudible 02:00:16]

CHAIRPERSON LEVIN: Um--

DR. MICHELLE ALLEN: Do you still want to know the level of cannabis in the system that results--

CHAIRPERSON LEVIN: Yes.

DR. MICHELLE ALLEN: in a positive--

CHAIRPERSON LEVIN: Oh, for sure. Yes.

DR. MICHELLE ALLEN: toxicology? For the casual user, two to five Nano grams per mL. For the longtime user, greater than five Nano grams per mL.

CHAIRPERSON LEVIN: Okay. That's in the newborn's blood. Or newborn's urine.

DR. MICHELLE ALLEN: The threshold level for cannabis in the system to warrant a positive toxicology is just an absolute number.

CHAIRPERSON LEVIN: Okay.

DR. MICHELLE ALLEN: I would hope that the newborn is not, neither casual nor long-term user.

CHAIRPERSON LEVIN: Of course.

DR. MICHELLE ALLEN: So, it's probably maternal.

CHAIRPERSON RIVERA: But you don't just test the newborn. I mean, you test the pregnant woman.

DR. MICHELLE ALLEN: There are obstetricians and their pediatricians. As they obstetrician, I test the newborn woman. The pediatrician will-- I test the mother, obviously. And as the pediatrician, the pediatrician will test the newborn.

CHAIRPERSON LEVIN: Okay. We're hearing that there is cases where, when a removal happens, that they family cannot be reunited until the mother tests negative for all drugs, including marijuana. But if we don't believe as a policy that marijuana use is, and in of itself, a risk factor for abuse or neglect, then why would we require somebody to test negative if it's not a risk factor?

ASSISTANT COMMISSIONER MARKS: So, that is not our policy to require to test negative to get your children back. So, when the children were initially removed, there would've had to have been other things that cause the removal besides just the use of marijuana. So our assessment for reunification would be whether they completed the

service plan that was initially established and then we would report that to the court who then makes the final decision about reunification. But we certainly don't have any policies that say that positive marijuana test will prevent reunification.

CHAIRPERSON LEVIN: Okay. Going back, Commissioner Hansell, to your testimony of OCFS, you said, we've been in conversations with OCFS and are verifying they SCR does not accept substance use related reports nor refer cases to ACS to investigate when there is no allegation of impact on child safety. Can you give us a little bit more information as to the status of those conversations? Have they been responsive to this?

COMMISSIONER HANSELL: Yeah. I mean, our understanding is that that is their policy, but we also have also heard anecdotally, as you have, that there've been cases where that hasn't happened. So we want to make sure that it is clear on their part that they would not accept those cases and they would not refer them to us or to any other county around the state for investigation. So, yes. And we can report back to you on how those conversations go.

CHAIRPERSON LEVIN: And let's see--

CHAIRPERSON RIVERA: So is it only the-- I just-- We just really want some clarification. Is it only the newborn positive test that results in a report to the state?

DR. MICHELLE ALLEN: Yes.

CHAIRPERSON RIVERA: So--

DR. MICHELLE ALLEN: And it's not, in and of itself, as we are hearing, that there needs to be actually collateral information that speaks to the behavior of the mother and what her-- whether or not she can parent.

CHAIRPERSON RIVERA: Right. So, because the all positive toxicology results have to be conveyed to the social worker. And that's either prenatal, labor, delivery, or postpartum. So though you might be gathering this information throughout the pregnancy--

DR. MICHELLE ALLEN: Uh-huh.

CHAIRPERSON RIVERA: it's only when you do the newborn test and it results positive that a report is made to the state.

DR. MICHELLE ALLEN: Yes.

CHAIRPERSON LEVIN: Okay. So I just have a couple more questions here. Commissioner Hansell, you mentioned in the hearing this past fall back, and as we just talked about, that marijuana use alone is not used to justify removing a child from the home, restrict parental visits, or keep the child from being united with their parents, however, we've been hearing, obviously, from advocates that the opposite is true. How does ACS ensure that the policies that you have spoken of throughout this hearing and at the last hearing are actually being implemented on the ground? So where is the quality control on a level from Commissioner down to CPS?

COMMISSIONER HANSELL: Yeah. That's a very important question and that is a major-- it certainly has been a major focus during my tenure at ACS and I actually want to answer your question in two ways, Council member. But the challenge-- And I hope I made this clear in my testimony today. The challenge of ensuring that, and every one of the 60,000 investigations lead to every year, our practice is entirely consistent with not just a policy, but multiple policies that govern how we do

that and how we make the decisions and the outcomes of those investigations. It's an extremely daunting challenge. I have never done the work myself unlike Associate Commissioner Marks, but I have shadowed CPS in the field, I have reviewed hundreds of case records, I've sat through hundreds of child stat sessions now, and--

CHAIRPERSON LEVIN: Uh-huh.

COMMISSIONER HANSELL: very often, these are incredibly difficult and nuanced decisions.

CHAIRPERSON LEVIN: Uh-hm.

COMMISSIONER HANSELL: So, it is critical and it's one of the most important things-- one of the most important aspects of our work to make sure that we are doing everything we can to ensure consistency between policy and practice. And we have put in place what I think are very robust quality assurance mechanisms to do that. Child Stat, of course, is a core part of that work and you know the history of the Child Stat and how we brought that back a couple of years ago and I think that's made a big difference. We have also instituted over the last year, year and a half, a process that Associate Commission Marks oversees where we, on a rotating

basis, we identify the highest risk cases that are under active investigation and make sure that they're not just being handled by the CPS team as they normally would, but they are getting a higher level of review from a team of quality assurance specialists under Associate Commissioner Marks' supervision and making sure that, you know, we identify any deficiencies in the investigative process. We give the input to the CPS team at a time when it can actually affect the outcome of the investigation because the investigations are underway. We need to periodic safety forms to reinforce practice with child protective specialists. We do ongoing training. So we have, I think, very robust mechanisms in place for the specific purpose of doing everything we can. I would never say ensure.

CHAIRPERSON LEVIN: Right.

COMMISSIONER HANSELL: I could never say that we could promise and every single case, but to do everything possible to align our practice in every investigation we need to with our policy. The other thing I would like to say, though, is I know, you know, you have heard and, from advocates and

elsewhere, instances-- and we do have regular dialogue, as I said, with the institutional providers, but if there are cases you hear about in which it appears that the practice has not been, I would very much encourage you to make them available to us. We, obviously, can't discuss them publicly--

CHAIRPERSON LEVIN: Sure.

COMMISSIONER HANSELL: but I can certainly commit that we will do a thorough review of any case that comes to your attention where it appears there may have been a misalignment between policy and practice.

CHAIRPERSON LEVIN: Right. From the CPS' perspective, how much weight-- or supervisors perspective, how much weight do we get is in the constellation of potential risk factors, how much weight do we get to marijuana use? Is there a scientific-- Is there a number that we can ascribe to that or--

ASSISTANT COMMISSIONER MARKS: No. There is definitely not a number that we can ascribe to that. It's, again, going back to looking at the impact on the child. I mean, marijuana use may mean absolutely nothing at all in terms of safety.

CHAIRPERSON LEVIN: Uh-huh.

ASSISTANT COMMISSIONER MARKS: Right? And then, on the flipside, there could definitely be impact on safety. It's really about making an individual assessment on a case-by-case basis.

CHAIRPERSON LEVIN: And then my final question. At the end of an investigation, does ACS provide details as to how to have a name removed from the SCR is that there is no findings?

ASSISTANT COMMISSIONER MARKS: Yes. So we give out once called a notice of if the case is indicated, and notice of indication and that is something that we are mandated to do and we give that to the parent and that notice gives them all the rights and the address to where they can write to request that.

CHAIRPERSON LEVIN: Okay. So we want to thank you very much. I think that there is a lot of work that we can do to gather take it clear data. This is an evolving field here because of the potential legalization of marijuana and we want to make sure that our system is more fair and that we are not disproportionately penalizing particularly women of color in our city for doing a practice that

could very well be fully legal and potentially not as harmful as many other substances that people consume during pregnancy and-- but without the data and without a clear picture, we can only rely on what comes to us in the anecdotal evidence that is presented to us and we need better clear information. And so that is what we are after here. And so we look forward to working with you all to try to achieve that.

COMMISSIONER HANSELL: And we do, as well.

CHAIRPERSON LEVIN: And alternate back over to my colleague.

CHAIRPERSON RIVERA: Thank you for your testimony. We look forward to working together.

DR. MICHELLE ALLEN: And I will just say that we are totally aligned.

CHAIRPERSON RIVERA: I hope you will stay for the testimony here. We have some attorneys who are on deck as well as hopefully personal experience that we can all learn from and gain insight. Thank you.

CHAIRPERSON LEVIN: Thank you very much.

CHAIRPERSON RIVERA: We're going to call up is Robin Wiley. And, again, thank you all for your patience. Nyla Natarajan. Jessica Prince. Jane Cooper. Brianne Ryer. And Shakira Kennedy.

[background comments]

CHAIRPERSON RIVERA: Yeah. Six-- Thank you all. As soon as you're ready to begin. If-- You don't have to be the first one. It's up to you all. And I just want to say how amazing this panel is. Just by the look of you.

JESSICA PRINCE: I'll go first. My name is Jessica Prince and I am an attorney with the Family Defense Practice at the Bronx Defenders. Thank you for the opportunity to testify today. I would like to share the experience of one of our clients, Marian, who gave birth to a healthy baby girl on a New York City public hospital. When she gave birth, Marian was tested for drugs. She was tested without her consent or her knowledge. When her drug screen came back positive for marijuana, hospital staff told Marian that they had to test her newborn, as well. But when Marian's baby came back negative for all substances, Marian was happily allowed to take her baby home. Her baby remained

home with her for two weeks. She attended not one, but two well baby visits with her baby. She was happy to see that her baby was progressing and growing as she should. It was during the second pediatric visit that she was notified that there had been a second toxicology test on that baby at the time of birth and that that test had been positive for marijuana. The pediatrician said that as a result they had to call ACS, but not to worry because the baby was clearly so well taken care of. It wasn't okay. ACS called. ACS knocked at the door the following day and the caseworker told Marian that she had to remove her baby. Now, in this case, Marian was able to convince the caseworker to wait until the father came home from work. That he would take work off and that he would take care of the baby. So, as a result, Marian's baby was able to stay home. But Marian was forced to leave her home and told to come to court three days later because this was a Friday night. Marian had nowhere to go. She had no attorney to ask questions of and she spent those three nights on trains on the subway. In court on Monday, once Marian was provided an attorney and she was able to appear in front of a judge, the judge

ultimately denied ACS' application to continue separating this family and Marian was allowed to go home under a list of court-ordered conditions, all of which were requested by ACS, which included a drug treatment program. Following the hospital testing of Marian in her baby, there were no services or treatment or follow-up care of any kind that was recommended or required for the baby or the mother. At the end of its investigation, ACS marked the case as indicated and, as a result, Marian's name will stay on the state central registry until Marian's baby turns 28 years old. Her name is on that registry and it will restrict her ability to get certain jobs and certain employment. So who all is affected or who is this happened to? Do you want me to stop?

CHAIRPERSON LEVIN: You can finish.

JESSICA PRINCE: Okay. So does this happen to? Just like the racial disparities in stop and frisk practices, the test and report approach taken by hospitals disparately affects mothers and newborns of color. One study showed that African-American women are actually 10 times more likely to be tested and a survey done of New York City

hospitals exposed what we suspect. That public hospitals serving poor women routinely test while private hospitals and upscale neighborhoods do not. New York law does not require drug testing. It does not require the reporting or filing of a case based solely on in utero exposure to marijuana or any other drug. There is simply no justification and what happened to Marian and her daughter in the name of child protection was unjustified by the law, science, or public health and it is not at all uncommon. It happens often and what I can say in response to what I heard earlier today on some of the testimony is that the hospitals absolutely do report mothers when they test positive for any substance, especially marijuana. That we see petitions filed in court against these parents when it is simply a positive toxicology for marijuana on the mother. No positive toxicology for the baby. We see those cases. And I also would like to just emphasize that who from the hospital is the one reporting? There is a policy set up of it was the one reporting and it is an obstetrician or pediatrician who is making a call to the social work staff who then reports it to ACS. And that's the way these cases come into court, into

Family Court, and it is absolutely a basis for the kids being removed. And I would just also like to say that it seems to be that there is a complete divide between the policy and the practice that is being talked about in this room. It may be policy did not remove children based on marijuana. It may be policy not to file cases based on marijuana, but it absolutely happens in practice.

CHAIRPERSON LEVIN: So, thank you. So, before we go on to the next panelist, just have a couple of questions on this.

CHAIRPERSON RIVERA: Do you want to [inaudible 02:19:15]

CHAIRPERSON LEVIN: I'll-- Okay. We'll wait until the full panel speaks.

I think you'll probably hear a lot of resounding points. So-- My name is Brianne Ryer and I'm a supervising attorney in the Family Defense Practice at the Neighborhood Defender Service of Harlem. As I submit this testimony today, one of our attorneys is on trial defending Mr. James. When Mr. James' son, Junior, was born, ACS commenced and neglect proceeding against him based on his marijuana use and removed his newborn son from his care.

Today, Mr. James and Junior remained separated despite the fact that prior to his son's birth, Mr. James engaged in both a substance abuse treatment program and a young fathers program to prepare for his child's arrival. Mr. James completed the young fathers program and continues in his drug treatment program to this day and is testing negative. However, ACS will not return Mr. James' son do his care because he is not yet fully completed his substance abuse treatment program which can be six months to nine months to a year. Amy had another case, Ms. Green tested positive that the birth of her child. She alone tested positive for marijuana at the birth of her child. With no other children and no prior ACS history, a case was filed against her based solely on the positive marijuana toxicology. ACS prosecution of marijuana cases is aided and abetted by public hospitals who routinely drug test our clients, predominantly black and brown women, with or without informed consent. We know that this is happening because of the petitions filed in court tell us so. The petitions tell us that the hospitals where our clients give birth are public hospitals, most frequently run by New York Health and Hospitals

Corporation. The petitions also tell us that our clients were subjected to intrusions on their bodily integrity in a way that wealthier, whiter communities are not. What the petitions do not tell us is whether or not our clients ever consented to these intrusions, whether they were ever informed to their right to refuse such testing, either for themselves or their newborn child, or whether they were ever even informed that the testing was done until the ACS worker visited their hospital room. We do know, however, that in at least some cases, these test are being affirmatively refused by our clients and our clients babies are being tested anyway. Evidence of this can be found in medical records received from ACS as part of discovery on marijuana cases. In reading through one such record, our attorney discovered that our client was informed by hospital staff that even if she didn't consent to herself being tested, the hospital would test her newborn child anyways. The hospital justified this threat under the guise of ensuring the safety of the child. Did they stop to consider whether or not they would make the same request of all wealthier or white mother and I will say, as Ms. Prince also noted in

response to some of the testimony we heard from Dr. Allen earlier, I personally and several of my colleagues and staff from two different family Defense firms now have been reviewing medical records for seven years and I have absolutely never seen the doctors note referencing informed consent whatsoever. Their waste is routinely reported in those records. Whether or not they are tested is. I have never seen a conversation about informed consent.

Unfortunately, these fact patterns are all too common for those of us on the front lines. Sitting in Family Court and observing the faces that pass through the revolving door of the child welfare matrix makes one painfully aware of just how overrepresented parents of color are in this system. According to OCFS' own data, in New York City, three force of children in foster care are black or Latino while another 18 percent are classified as unknown race or ethnicity. Only six percent are white. In other words, it appears that potentially 94 percent of all children in foster care in New York City are children of color. If what we see is indicative of reality, then the only parents who use marijuana are poor mothers of color. But we know that is true. A

former council member who was with us before made the observation, and it's a correlation that defense counsel makes a lot between stop and frisk intrusions and these intrusions in testing-- Obviously, stop and frisk was found to be unconstitutional, but I think, for us, it's even more alarming because, instead of searching someone's pockets, they are searching our clients wombs and they are searching our clients homes, their blood, their hair, and all without the informed consent that was indicated. I think, at best, there is a gaping disparity in the policies being discussed before the Council and the actual application we see in court. But, most importantly, the applications and the way it affects our client families. Thank you.

CHAIRPERSON LEVIN: Hi. Good afternoon. My name is Jane Cooper. I am an attorney with the legal aid Society's juvenile rights practice. We represent the majority of children whose parents are charged with abuse or neglect in Family Court and we think you for the opportunity to testify today about this important issue. As this council is well aware, the child welfare system has a profoundly disproportionate impact on families of

color in New York City. The same disparities exist when looking at the NYPD's policing of marijuana in New York City. As a result, we have to look very carefully at what our policies are and how they are implemented. Determining when drugs, including marijuana, is a factor in child maltreatment is an ongoing challenge. Substance abuse is considered within the child welfare community to be a contributing or aggravating factor and at least half of all child maltreatment cases. However, it has not been established that marijuana use by parents correlates to harm to their children. In fact, Columbia University neuroscientist, Carl Hirt, who testified on this issue before Family Court in New York City, posits that, quote, the belief that casual marijuana use impairs your parenting has no scientific basis and pot use that is an excessive is on par with having a drink now and again, end quote. Whether parental marijuana misused, or use. I'm sorry. Poses a risk of harm to a child is dependent upon the individualized circumstance of the parent and family. ACS should be working to determine this risk using science and best practices. Instead, New York law says that a parents repeated misuse of an

illicit drug, including marijuana, is considered prima facie evidence of neglect unless that parent is also voluntarily and regularly participating in a rehabilitation program. In other words, the parent who recreationally uses marijuana, repeatedly, or tests positive for marijuana on multiple occasions demonstrating repeated abuse is presumed to pose a risk of harm to their children that amounts to the level of neglect. This is been borne out repeatedly in case law which finds that repeated use of marijuana in fact, by itself without any demonstration of how that marijuana use impacts the child, is neglect. New York law, in effect, equates this repeated abuse with abuse or misuse that would potentially, and certainly not in all circumstances, but could potentially pose a risk of harm or harm to a child. This law, coupled with racially biased policies and practices in law enforcement and in the child welfare system, has a profoundly negative impact on families of color in New York City. Mandated reporters in New York are required to make a report to the state central registry when they have reasonable cause to believe that a child is being neglected, including parental misuse of drugs like

marijuana. Even in cases involving what is ultimately recreational marijuana use, and suing investigations can lead ACS to impose safety plans that demand cooperation with preventative rehabilitation services. Failure to comply with these plans puts parents at risk of court involvement and ultimately removal of their children. Even without court involvement, parents risk placement on the state central registry for neglect which, in turn, negatively impacts their employment opportunities and corresponding ability to provide a stable environment to their children. And indicated case on the state central registry, as well as misdemeanor conviction for marijuana related offenses also frequently prevent relatives coming forward to care for children in foster care from becoming certified foster parents. We support the specific resolutions and bills proposed by the New York City Council and provide several additional recommendations. Resolution number 740, which cause upon ACS to implement a policy finding that mere possession or use of marijuana does not by itself create an imminent risk of harm quarantine removal should be expanded to include to prevent mere

possession or use to serve as a barrier to reunification of a child, as well. We additionally suggest that the city Council call on ACS to implement a policy of not filing neglect cases based solely on a parents use or possession of marijuana without a clear and articulable showing of the harm that such use or possession has caused or is at risk of causing to the child. Manhattan and Brooklyn district attorneys have enacted similar policies with regard to the prosecution of marijuana offenses in the criminal justice system. We further suggest that the city Council call on ACS to issue guidelines based on past practice and science to assist those who work in the field to determine whether marijuana use prevents a parent from providing adequate supervision and protection of their children and also detailing the impact that marijuana use should have on decisions regarding the parents need for services or a child's placement or continuation in foster care. Finally, we ask city Council to call on ACS to issue a policy that prior misdemeanor marijuana convictions, by itself, should not be the basis for a discretionary denial of a foster parent certification for relatives coming forward to care for children

placed in foster care. I would like to just add one piece that is in our-- point you to one piece that is in our written testimony, which is not necessarily perfect data, but to provide some information to the Council. We reviewed the neglect proceedings from 2017 in which we were appointed to represent the children in those cases. There were approximately 1200 cases that included some type of drug allegation, substance abuse allegation, and approximately 400 of those were only involving marijuana. That's not to say that there are other allegations in those cases that were filed, but with regard to the substance abuse allegations, just over 400 of them involved only the use of marijuana. In at least a significant number of those as pointed to by others testifying here today, those-- the marijuana allegation was the sole allegation for neglect. Thank you.

CHAIRPERSON LEVIN: Thank you.

NYLA NATARAJAN: Thank you. Good afternoon. My name is Nyla Natarajan and I'm a supervising attorney at Brooklyn Defender Services in the Family Defense Practice. Today I would like to focus your attention on the ways in which current

practices perpetuate extreme and disproportionate consequences of marijuana use for poor communities and communities of color and, in particular, the ways in which marijuana use is used as a barrier to reunification. That is, to keep children in foster care and, as a reason to prolong government surveillance over our families. Every day in Brooklyn Family Court, marijuana use is almost always conflated firm misuse and neglect by ACS. That is to say, Family Court, ACS, and the law make little to no distinction between recreational or thoughtful and safe use of marijuana by a parent and the use of drugs that has an actual and quantifiable harmful impact on children. This misinformed assumption almost always leads to a demand by ACS that parents practice total abstinence in order to regain custody of their children from foster care or to close the case and end mandated ACS surveillance over a family. So we heard testimony today that it's not ACS' policy to demand someone test negative before their children are returned, but, in practice, that is what ACS demands. While marijuana use may be the cause for initial filing of neglect or the removal of a child, it is even more often used as a barrier to reunify a

parent with their children, to the favorable or timely settlement of a case, or as a means to prolong a, as I said, needless state surveillance over marginalized families. This means that, even if the allegations of neglect against a parent do not reference the parents marijuana use, the Family Court and ACS can and do still require that parents abstain from using marijuana and it's a two-man that comes with extreme and punitive consequences. In this way, marijuana use is used as a way to arbitrarily impose moral judgment on our clients, a reflection of class and race-based prejudices. I want to be clear about two significant ways in which these consequences manifest for our clients. First is that they are asked by the threat of child removal to participate in a full drug treatment program. This can include going to treatment 3 to 5 times a week for several hours a day and then you continue to submit to random drug tests for an indefinite period of time even after having consistently tested negative for marijuana. It may even include a full time inpatient drug treatment program. This demanding schedule can severely limit our client's ability to gain and maintain employment, to pursue an education, or even

the spend time with their children. I have repeatedly been told by my clients that they have lost their jobs because of the demands of these drug treatment programs. Second, our clients and their children continue to remain separated, meaning there are children in foster care today for extra months or years who can only see their parents and supervise settings twice a week for maybe two hours because their parents have not completed a drug treatment program. It's important to remember that foster care correlates with worse outcomes at every stage of a young person's life and that the trauma of separation as we've seen at our country's border with Mexico leaves lasting scars. We are irreparably harming children and families with our current practices. We call on the city Council to increase the transparency and accountability of ACS and health and hospitals in their investigation and reporting of marijuana related cases to be a leader in the efforts to increase protections for patients requiring written and informed consent for drug testing and we call on a clear policy by ACS prohibiting any adverse action against a parent for the mere possession or use of marijuana. I would like to share three client

stories in which the stigmatization and punishment have-- are clear. Ms. G's children were removed from her care due to an unexplained injury to one of her children. After obtaining medical records, it was clear that her explanation was a reasonable and consistent with that child's injury. At that point, her children had already been in foster care for several months and the only barrier to her reunifying with her children is that she was testing positive for marijuana, again, not part of the initial allegations made against her. Her children were only returned to her are once she completed a drug treatment program and consistently tested negative for marijuana. This delayed her reunification with her children by seven months.

Ms. P and her child tested positive for marijuana at her child's birth. ACS was called and, for 16 months, she engaged in a drug treatment program at ACS' request. When Ms. P continued to recreationally use marijuana, ACS filed allegations of neglect against her alleging that she failed to voluntarily engage in a drug treatment program and sought an order that the court granted that she be excluded from her home. Ms. P visits with her child

nearly every day without any reported safety concerns, but cannot be alone with him and cannot return to her home because she continues to use marijuana and has not entered a drug treatment program.

Lastly, Ms. F tested positive for marijuana at her child's birth which triggered ACS entering her life and filing allegations of neglect against her. ACE recommended that she engage in a parenting course, domestic violence counseling, a drug treatment program, and mental health evaluation. Daunted by this litany of services, Ms. F decided to arrange for her mother to care for her child. ACS continued to pursue a finding of neglect against her and, though she visits with her child nearly every day with, again, any reported safety concerns and she continues to plan for her mother to care for her child, ACS continues to request that she complete a drug treatment program for marijuana. Thank you.

CHAIRPERSON LEVIN: Thank you. Just make sure the microphone is close. You can pull it over to you.

SHAKIRA KENNEDY: Okay. Freaking me out. Hello, city Council members.

CHAIRPERSON LEVIN: If you could pull the microphone a little bit closer.

SHAKIRA KENNEDY: Oh, I'm sorry.

CHAIRPERSON LEVIN: That's ok

SHAKIRA KENNEDY: Okay. Thank you so much, city Council members, for listening to our voices today. I'm sitting in the back and I felt like you guys were superheroes because you were literally asking all the questions I continuously asked and I continuously ran into the same road blocks you met today of indecisive answer, very gray area, sort of answers. So I just-- I appreciate you all so much. My name is Shakira Kennedy. I'm 29 years old and I'm a mother of three beautiful children. My twins just turned a year in March, my 7 year old daughter, who is my eldest, goes to one of the top three schools in the entire borough. She's also in the gifted and talented program. She's been in that program since kindergarten. She's in second grade now and she's also a Girl Scout. I'm a very dedicated mother. I had all three of my children with the same person, the same man who I've known since high school. We were on the verge to become a married and we were very happy parents. My pregnancy

with my twins was extremely hard. Just to give you some sort of idea, I weighed close to 160 or so pounds pre-pregnancy. At the end of my fifth month I was less than 110 pounds. I couldn't keep anything down. Just taking my daughter to the bus stop which was two blocks away took me a half an hour so I would have to plan accordingly to take her to that bus stop, make sure I don't pass out, and see her get on that bus, and then walk home. It was very difficult. Their father worked in the day time at that point in time, so he wasn't home to deal with all of this. This was my job as their mother. So it was extremely hard. I sought out what I felt was the best medical care for my children because I read and researched having twins usually comes with complications three out of the four times, so I made sure I am listed in a hospital that had at least a level III neonatal care unit or so, God forbid, something were to happen to my children, they are where they are supposed to be. I had a lot of emergency trips because of severe dehydration and in one of those trips, I disclosed to the physicians that I take marijuana to help with the nausea because I couldn't eat. I was throwing up more than I was consuming and I had to help my child

with her homework. You know, this wasn't my first set of children. So I was told that was fine. It's okay. They asked me-- Oh, I'm sorry.

CHAIRPERSON LEVIN: Just keep going. Don't-- Don't-- Pay no attention to the buzzer.

SHAKIRA KENNEDY: Sorry. Okay. They asked me if they could drug test me and I told them no, however, hours later, a s-- I guess a medical assistant snuck in the room and advised me they drug tested me anyways, but don't worry about it because this is just going to be in my medical record. I didn't hear anything about this until after I gave birth to my children. They were of healthy weight of which twin babies are supposed to be. Naturally, twin babies are not going to be the same size as a normal single child because it's two of them in there. Logic. But ACS did not see it as that case. My boys were tested for-- They tested negative for any drug in their system. I do not drink. I don't smoke cigarettes. I'm a hard-working taxpaying citizen and none of that was taken into consideration. Because I was positive with marijuana, the doctor advised me, well, you know, you're positive. We tested the boys, but we are

still going to have to report you to ACS. I guess, if that's just the job, then that's just a job. There's nothing I could do with that. You are usually allowed a three day stay in the hospital after you give birth and on my third day ACS met me at my bedside and gave me the paper letting me know they are launching a 60 day investigation and they are investigating me because the hospital had called them. They had concerns about my marijuana use. The hospital never asked about my seven-year-old daughter who has amazing credentials. It was never discussed on how we were living. I have a one bedroom apartment. I take very good care of my children. None of that went into consideration. Just because-- I don't know. Because I'm a black woman no one cared at that point in time. A lot of these social workers within the hospital were kind of splitting hairs because I told them I'm not going to breast-feed if you guys are trying to make me seem as a drug addict, I don't want to make it-- I don't want to endanger my children's life if this is the belief that that is here. So, I had some social workers telling me, no. it's okay. You're fine. And then I had other social workers telling me, well, if you just make sure you

do everything that ACS requests you to do, then you should be fine. So I did not breastfeed my children because of that. Two to three days later, after leaving the hospital, I had to go to the intake meeting because the same ACS workers met me at my hospital bedside went home with me, beat me home and saw my children's father who wasn't living with us. We were working to get married. They saw him washing our clothes because, obviously, I couldn't do it. They took down his name and threw him into my case. So now this man-- I have no idea where he is because we've had a huge following out as anybody wide. You know? Is not home and the kids really miss him and it's just because of me for partaking in marijuana. They said-- And this is not hearsay. This is what ACS wrote in the intake meeting. He sat down and watched me partake in marijuana, so he is responsible for the marijuana misuse. So he got thrown into my case and they, basically, suspended my case because they couldn't find him. So I had to take my babies to this outpatient program three days a week with actual drug users. They did not have their shots. They were, literally, 3 to 4 days old. I had to take my children to this outpatient program for at least 5

to 6 hours three times a day. I mean three times a week just to sit in a group of other parents who were-- some are trying to go to school. Some had to quit work because they had been reported marijuana users. You said in that room and you think you are going to sit with such monsters and people who beat and hurt their kids. You are sitting with people who are trying to graduate with a bachelor's or Master's, but got caught up in the system because of their color. So it's very hard and I just-- I appreciate you guys so much for listening because these are the questions us as parents have. Whenever you ask a direct question, it's met with an answer of, well, it cannot be answered because not everyone has the same case. The drug testing, the voluntarily drug testing, that they tell you you can kind of take, they also let you know if you don't take it, your children will be removed in court. So once I took that test, I naturally asked what is the results of my testing? And I was met with, I cannot know the results of my testing. When I asked my caseworker, can I get the results? She then told me I could go to the facility to get my results and the facility told me they do not do that. They only disclose my

voluntary results to the caseworker. If I wanted, I would have to subpoena them for my own results. So it's a lot that they were saying here was very-- very hard for me, so I'm so sorry if I was back there just being a bit much and emotional. And I want to make it very clear I am for ACS. We need ACS here. However, there needs to be a complete change in how they are managing people. I had no marijuana within my system within the first week of going to the outpatient program, however ACS very much forcibly forced me to stay in that program for at least three months. I had to complete it. No other choice. I had the people in charge of the program calling ACS every day and asking, why is she here? She is testing negative. And they just-- she has to do it. It's court ordered. She has to do it. My caseworkers at the outpatient rehabilitation programs also had to call ACS in regards to the cribs because they said I didn't have sufficient betting for the children, so they were going to require-- they were going to get that for me. And I didn't get any of that until the end of my drug treatment program which was months later. They never offered me child care for my children going to school-- I mean, going to

daycare while I went to this program. Nothing. They tried to-- At the time, my daughter was suffering in school because I am the main person who tutors her in, because my pregnancy was so complicated, course, that started to lapse a bit. She had a little decrease in grades on the caseworker told me if I don't get her grades up, they are going to have two remove her. So it's been very hard to have strangers come to your home and check for food in your friendship in your cabinets every visit they come. Take pictures of my kids Social Security cards and birth certificates with their cell phone. I don't even pay with a credit card in a restaurant how to fear of identity theft and yet this stranger, with their cell phone, is taking a picture of my children's birth certificates and Social Security cards. If you could please eliminate that because I don't understand what's the basis of that and why is that needed and an ACS case. If it's just for something that is just-- sorry. I'm getting a little emotional again.

CHAIRPERSON RIVERA: No. Thank you. Thank you for sharing. Thank you for--

SHAKIRA KENNEDY: Thank you. It's a real burden for mothers of color that are happening today because just off of simple marijuana use your children are being removed and I have met other mothers who they have done this to. Because it happened so quick you think it's more so of a joke or not really a joke, but you-- it's just surreal. You don't think this is going to happen. You give birth. ACS need to the very next day and then two days later you get a court order. You're not healing in any of this as a woman, so there was one case a mother, she didn't go to court when they did and they took her child away within five days of her just giving birth. These are the people who are filling the outpatient rehabilitation programs. Not actual addicts. People who are hard-working and just got caught up in a system where anyone is characterized as a neglectful parent for any reason. A pedophile has more rights than we do right now because from a level I or level II, I can tell if you saw a kid or if you did something in a park. I can tell a difference. There is no difference with ACS is what I'm trying to say and that's not right. Not every case should last two months. What is there to investigate in two months

if there is no damage to the children? There's no problems. There's nothing. In the instance of my case closing, coming to a close, my lawyers did ask-- Well, they petitioned for ACS to submit the proof that they had of actual neglect. They had to do this in a specific timeframe of five business days and, miraculously, without anything being submitted, a new case got opened up on me. With the same caseworker that I have beforehand. And, surprisingly, she came that day just to let me know she's going on a three week vacation. So I had two cases open on me for no reason and I couldn't fathom how fast everything was moving. They went and interviewed my daughter by herself and her biblical summer camp. They took her out of her class and put her in her separate class and it was to caseworkers that interviewed her. And, offer the initial visit, she asked me, mommy, how many lawyers do I have? And I had to advise her, honey, you only have one. You met your child's law. You just met her. Then she told me, well, why did that other lady tell me she was my lawyer? And it's just-- there's too much of a gray area where the caseworkers and the supervisors can literally do whenever they want and there is no suffering for

that. The judges take everything of what they say into consideration and you, as a parent, if you're not squeaky clean, you are automatically guilty. This care worker-- This caseworker is writing statements about you in a notebook with a number two pencil. There is nothing actually documented. These people need to wear body cameras because, if you're going to speak to someone's child by yourself, this needs to be something that is shown in court as proof, not something that you wrote in a marble notebook and that alone puts me on the state registry for all of my working career life. I cannot work in a hospital. I cannot work in a school. I worked in a pharmaceutical medical science college for more than 10 years. I can never look to a job like that again because I'm on the state registry. And now I am a statistic living as a single parent with three children and now I believe I'm a burden on the state because I have to apply for all these different state benefits because ACS drove the father away. So I'm not saying that ACS is so terrible. They just need to revamp it. Please revamp them. They cannot continue to do this to people of color and sit here and say, well, we're not going to give you statistics

on how many people we get out of this neighborhood, but we are going to give you statistics on how many people use drugs. How many people use drugs? That's tomatoes and tomatoes. Just please revamp them and I'll leave you like that. Thank you so much.

CHAIRPERSON RIVERA: No. Thank you, Ms. Kennedy. And we're trying to get to that. Just the data that they don't track-- Because we know what it's going to tell us. Right?

SHAKIRA KENNEDY: You know? How many people had cases and Flatbush compared to people who live in downtown Brooklyn or Borough Park?

CHAIRPERSON RIVERA: I'm sure. I'm sure. So we are-- that's why we have this hearing today and thank you again for sharing your story and being so open with us and real about it.

SHAKIRA KENNEDY: Oh, yeah. I'm an open book. Thank you so much.

CHAIRPERSON LEVIN: Ms. Kennedy, just want to thank you for speaking and telling us your story. And there is no reason in the world why you should be on any registry of any kind and you should be able to support your family and any field that you want to work in and you certainly have our commitment

here at this committee that we will work with you and work with ACS and OCFS to make sure that we have a fair resolution that brings you some semblance of justice, but just as importantly that we are looking out for other mothers who would be mistreated the way that you were. And you have our commitment that we're going to continue to--

SHAKIRA KENNEDY: This means a lot because sitting in a program where you're being told as a woman, man, black, white, or blue, that you are not a good parent and that you've been taking care of them all your life, it really hurts you in a way that a knife or a gun can't. It's very hard when you have to sit there listening to professionals tell you, no. You are wrong. You endangered your child and you know you didn't. So just think you guys so much.

CHAIRPERSON LEVIN: And how are your babies now?

SHAKIRA KENNEDY: Driving me crazy, but they're amazing.

CHAIRPERSON LEVIN: I know.

SHAKIRA KENNEDY: But they're amazing. Medically perfect. Everything. Just thank you so much.

CHAIRPERSON LEVIN: Great. Thank you.

ROBIN WILEY: And I, too, would like to thank you all for listening to us today. My name is Robin-- I'm Robin Wiley, a parent leader at Rise. Rise supports parents to become advocates for change in child welfare. I'm a parent who was affected by the child welfare system. From being on that side of the table, I can now support other parents and train professionals working in the system to understand parent's perspective. I'm here today to support changes to the law and policies that will reduce the fear and injustice that exists in my community because of the threat of ACS investigations and family separations. Unfamiliar with the fear that can present and apparent from seeking help. When the crack epidemic was going on, many children were being removed from the arms of their parents, especially in Harlem and South Bronx. This made me very fearful to ask for the help that I so desperately needed. Two of my three children were removed from my care a year before I realized I was pregnant with my fourth child. I feared going to get prenatal care constantly thinking that, if I did, my baby would be removed at birth. That fear prevented me from

getting the medical care treatment I should have gotten during my pregnancy. Use of marijuana is not a safety threat. Use of-- Oh. My on the wrong page? Sorry. I should have gotten the help I needed during my pregnancy. The day after my baby was born with positive toxicology, he was removed. I was tested without my knowledge or my consent and the response was to discharge me alone without my son and without any help. If I had just had an open and honest doctor to speak to and asked me what was going on, Amanda felt comfortable and been able to get help. Someone should have offered me services, not just sphere. Research now says it's important to do everything possible to help parents keep the bond with their newborn child. That means programs where parents and children can go through the journey of rehab together. And policies that tell parents, as long as you keep doing what is best for you and your child, you don't have to be concerned about your child being removed. That wasn't the message I got. I felt trapped. And alone. Today, fewer children are removed from their parents than they were when my children were in the system, but more parents than ever before being investigated. The fear that

parents feel when getting that knock on the door cannot be overstated. Parents and my community today are still living with the fear that they will lose their children based on their drug use. That causes parents who need-- who need help not to get it. Some parents don't need help because their use of marijuana is not a safety threat to their children. These parents can still feel threatened and unsafe. As one parent wrote for Rise, when we are investigated, we don't expect it to be fair, so when we hit a crisis, our fear keeps us hiding under a rock. To feel safe, parents need clear information about the law. ACS should report on how often hospitals are making reports against parents. Hospitals should not use-- hospitals should not drug test patients without their knowledge and consent and should not report drug use as child neglect without evidence of harm. Hospital policies should include how they offer help, not just judgment. In order for parents to have a different perspective on how to do with the issues in their lives, they need assurance that help is available in their communities and hospitals without the fear of having their children removed. As we move forward to the legalization of

marijuana, parents need to understand how this may or may not affect them. ACS should make clear that children will not be removed because of parents marijuana use when there is no harm. It's so important to reduce fear and that can only happen if we stop unnecessary investigation and removals. Thanks again for listening.

CHAIRPERSON LEVIN: Thank you. So I just want to say to this panel thank you for staying to present all that you presented to us for this hearing and for the record. I don't think that there is ever-- I can't recall. I've been here for nine years. I don't think there's ever been a hearing that I can remember where the testimony of the administration is so different from the testimony that was presented by the advocates and people that have lived it. And that is really concerning to me. It was as if we are living in two different dimensions and that both of them can't be right, basically. So I think we have a lot of work to do to make for a better system that really, truly reflects what we say is our policy and what we say are our aspirations. They said earlier that they are meeting regularly with legal services providers. I don't

know if that is really happening, but we-- we're going to rely on you, this panel and anyone else you want to bring to the table to make sure that this policy is corrected and I'm here for another two and a half years any of my commitment all work every day of those two and a half years to try to do this. But I certainly need your advocacy and help and, really, I will follow your lead. But I want to thank you.

CHAIRPERSON RIVERA: And I think it-- You know, what you said, Ms. Wiley, about that a parent said when we are investigated, we don't expect it to be fair. I think that goes for most things affecting communities of color and women of color. And so, for you all to be working collectively to stop it and to make this a better system which is clearly very broken, it means a lot to us that you would dedicate yourselves and your time. So thank you.

JANE COOPER: Thank you. Thank you for listening.

CHAIRPERSON RIVERA: We're going to call the next panel. It's Clark Wheeler, Dionna King, Greg Waltman, and Nahal Zamani.

CHAIRPERSON LEVIN: I have to run downstairs. I'm so sorry.

CHAIRPERSON RIVERA: That's okay.

[background comments]

CHAIRPERSON RIVERA: Where is he from?

[background comments]

CHAIRPERSON RIVERA: So, I should start with him so we can get it over with?

[background comments]

CHAIRPERSON RIVERA: Okay. Oh. Thank you.

NAHAL ZAMANI: On behalf of the Center for Constitutional Rights.

CHAIRPERSON RIVERA: He's going to start the clock. Hold up.

NAHAL ZAMANI: That's fine.

CHAIRPERSON RIVERA: Thank you.

NAHAL ZAMANI: Sure. My name is Nahal Zamani and I'm an advocacy program manager with the Center for Constitutional rights and we would like to thank you guys so much for chairing this key hearing. We were struck by the morning, the earlier testimony, particularly because it talks about the role in the discretion that's afforded and the stigma and harm

that results as this practice. It's really compelling because, as my colleagues will testify here today, New York is really on the cusp of legalizing marijuana and, at the same time that there is this greater appreciation and consideration of the use of marijuana, the prevailing mechanisms around child welfare are falling greatly behind. And it's not only-- This is the opposite of harm reduction. This is actual, literal harm as was demonstrated by the powerful testimonies that preceded us. I'm really struck by the roles of H&H and ACS here and really thinking about are these the most effective and sound interventions that can be made for the well-being of families not to be separated, for mothers and their newborns to be safe? And really thinking about are these practices simply promulgating stigma and exacerbating and spreading harm? Particularly with regards to H&H, a few things. They discussed, perhaps for the first time in public, the indicators that they are thinking about that feed into decisions for healthcare providers to test for drug usage. One of them included mood swings, which is absolutely almost laughable because that is pretty much an indicator of

pregnancy. So it's almost a guaranteed indicator that presents itself during pregnancy. It's almost mandated by the sheer volume of hormones that we as mothers face. Another is access to prenatal care. And this is so striking to me because, as we know, help disparities in health outcomes, particularly for women of color, especially for black woman in this city with so much privileges absolutely unequal. And so, factors behind having access to healthcare are very much the need for more interventions to meet moms that where they're at. Not a predicate for judgment or harmful intervention that actually could lead to their child being taken away. It shows the reasons why Resolution 746 are so key, why we need to streamline hospital procedures around who is being tested, what is the basis for those tests. We need to be grounding interventions and harm reduction and that is working to reduce stigma. We need to ensure that all patients are fully informed and are able to give consent freely. And we know, as the council members testified, we've seen it in the policing context. Consent is not given without the factors the power being at play and that is absolutely a factor in hospital or health administrative setting.

We are also extremely disturbed by the earlier testimony regarding consent practice by H&H along these lines which, as we know, when government policies are disparate, are different, they are absolutely prone to abuse. Lastly, as a mother, childbirth, pregnancy, and the immediate. After is an incredible and complicated experience in the fact that they are being government interventions that are leading to family separation, whether it's happening at our southern borders, whether it's happening uptown, you're here in New York City, is incredibly disturbing. Any type of removal, whether it is three days or several weeks has severe ramifications for infants, for bonding, for the ability to establish breast-feeding, and the well-being of outcomes. Attachment for infants is one of the most crucial outcome indicators for how they are going to proceed in life and how they are going to thrive. So the fact that government interventions are ineffective, that are really stigmatizing and criminalizing particularly mothers, as opposed to reaching them where they're at and helping them when they need it most is absolutely disturbing. So, we are so glad that you are holding this hearing today. We are very

appreciative of the package of bills, the two bills on public reporting and the two resolutions which really look at policy changes that need to happen both at ACS and at the state level. And in our testimony, we have further enumerated wide today and in the coming months truly changing the way that we are operating here and New York has to fundamentally change. Thank you.

Thank you. Let the record show that I am not Dionna King. I am Cassandra Frederique, the New York State Director at Drug Policy Alliance. Dionna had to book it, so I had to tag in. Okay. So Drug Policy Alliance is ecstatic that the New York City Council is looking at these issues and has introduced two pieces of legislation and resolutions around this issue. I think it's critical for us to recognize that in order to dismantle mass incarceration, we have to expand the lens to really look at all the institutions that criminalizes are communities. And by expanding the lens, we are able to have more gender responsive analysis of how criminalization is impacting New Yorkers throughout the city. The ability for child welfare agencies to go untested and unmonitored is what happens when we de-prioritize

women and their autonomy. The criminalization that has gone on for parents in New York City is really just a testament to how much we don't pay attention to the harms that happened to black and brown bodies. It's gone on too long. It's irresponsible. And so I am incredibly encouraged that the Council is taking this on in such a thorough way. I would offer that this conversation is happening around-- within the context of marijuana legalization, but it is our position that Drug Policy Alliance that these policies should not stand for any drugs. That we should not create a set of policies associated just for marijuana, but that we should be looking at all drugs in the ways that child welfare do not support parents that may be struggling with drug use, especially within the context of the overdose crisis. This is imperative that we support parents at this moment. And you can see the racialized response to the way that we treat parents and we treat children and the fact that we are talking about it was crack babies and now it's Americans orphans. You know, it's crack moms and now it's-- it's, you know, parents that are struggling that are at the margin, diseases of despair. And so we really have to take

that mandate and recognize the way that our racialized policies have even influence the way that our institutions criminalize communities and groups. We would offer that-- DPA asks the Council to not only support reporting legislation, but also challenge the use of drug testing on pregnant people prior to delivery or the testing of newborns postpartum. We think that if you talk to doctors that are doing this work, they would seriously question the use of drug testing and any-- in most fashions. This is-- You know, we often talk about disparities and I think, for us, it's not that we want more people to be tested, we want the idea of testing to be questioned. The other thing that we would say is that further legislation that Councilman-- Council member Reynoso introduced, the counselor should consider amending the legislation to reflect our desire for data transparency. As the legislation is currently written that the data will only be accessible to the Mayor and the members of city Council. This data is crucial to our community for us to know what's going on and it gives us more agency about what institutions we interact with every day. And, lastly, I would say the resolution in

general for resolution 740, it's important for us to challenge ACS to shift its organizational priorities to become an agency of support and the reduction of harm as opposed to punishment and enforcement and another vehicle of law enforcement. I want to go on the record and think Dionna King for preparing this testimony.

CLARK WHEELER: Good afternoon. My name is Clark Wheeler and I am a Government Relations Associate at Planned Parenthood at New York City. Thank you to committee Chairs Levin and Rivera, as well as the Committees on General Welfare and Hospitals for convening this hearing and to all the sponsors. Planned Parenthood of New York City supports introductions 1161 and 1426 and resolution 740 and 746. PP NYC provides essential sexual and reproductive health care and innovative education programs throughout New York City. As a healthcare provider, we recognize the vital importance of building trusting relationships between our patients and providers. Our patients often come from communities that have historically experienced medical violence and may continue to lack trust in the health care system. One persistent form of

medical violence in our healthcare and child welfare systems is the practice of punishing and separating families based on the parent's substance use. In New York City, this is a crisis impacting communities who also routinely experience sexual and reproductive oppression including women of color, immigrants, and low income New Yorkers. They idea that newborns and children should be separated from their parents because of marijuana use is rooted in racist, classist, and misogynistic ideologies that's specifically target women of color and low income parents and communities. Furthermore, number of commonly held misconceptions about substance use contribute to the demonization and criminalization of mothers and parents who use marijuana. As we have discussed today, studies show however that marijuana used during pregnancy is not independent risk factor for adverse neonatal outcomes. Studies also show a double standard when it comes to marijuana use and parenting. In fact, black Americans use drugs at approximately the same rates as white Americans, but are 10 times more likely to go to prison for drug offenses. In one study mentioned earlier today, black women who tested positive for illegal

substances were 10 times more likely to be reported to child protective services. The legislation being discussed today creates an opportunity for the city to begin to address the city of marijuana policies on a child welfare system and its particular harm on communities of color. In the face of attacks from a federal administration that is intent on separating families, New York City must be a leader in keeping families together and upholding reproductive justice and are child welfare systems. PP NYC urges the Council to pass this critical legislation and looks forward to continued partnership with the city as we work to improve the lives of all children and families. Thank you.

CHAIRPERSON RIVERA: Just really quick question and, ladies, if-- in your work, in doing this work, have you ever requested data anything like-- I mean, some of these studies that we have seen nationally, locally, and statewide, clearly point to the racial disparities that we know already exist in food, education, healthcare, and housing. So in terms of your relationship with the agencies that testified here today, has there been any sort of, I guess, cooperation or collaboration? And only

because I am referring back to my Council-- my colleague's comment and that the stark differences and what was in their testimony versus the advocates, the mothers, and everyone here today is absolutely astounding.

CASSANDRA FREDERIQUE: Yeah. So I would offer that Drug Policy Alliance has reached out to ACS and the data that we were able to receive was not complete and part of the reason why we knew that we need data because they're not actually required to have it. There have been conversations with ACS with some people within the organization with myself particularly talking about how to move ACS to harm reduction model. When we've talked to other advocates in the space, we realize that the problem was a lot bigger than a training and that we actually needed a fundamental shifting and that us engaging with the agency around doing trainings would actually make it more difficult for us to get to the questions that we're talking about today. And it's hard for us to work with people that are unwilling to see the full picture, which is evidenced by the testimonies that were given a day. But I do want to go on record that we started there. And recognize that the

problem was too big and we weren't operating-- there's no both sides to racial discrimination. There is racial discrimination and its disingenuous for us to engage in that kind of conversation when the facts are not the facts.

CHAIRPERSON RIVERA: Thank you. Thanks.

GREG WALTMAN: Good afternoon, Council member. General council. I'm Greg Waltman. I have a clean energy company. You're right, Councilwoman Rivera. It seems that there is a difference between advocates and people testifying in the testimony which is indicative of similar kind of circumstances where you have lawyers and judges doing-- saying one thing and doing another. So, obviously, parsing that type of narrative into a larger context, we have issues in the administration, obviously, Christian Nielsen just departing. But does that necessarily signify any type of change in the type of emigration dialogue? Not necessarily. And why is that? Because there is this value hyper protectionists limited scope cloud that prevents a larger dialogue around these types of issues. And what I'm alluding to is that-- and where energy, clean energy comes in-- I know you deal with hospitals, but is that if

you put solar panels on the border wall 10 feet 2000 miles-- say you don't even get 2000 miles, but at 2000 miles it becomes some 291 billion dollars of revenue per year at 12 cents per kilowatt hour. All of a sudden, you are exporting energy for cheaper where now you are reducing the barrier entry for Latin American citizens to participate in the economy resolving chain migratory issues because therein lies the opportunity that is in the United States has now been created in Latin America due to energy price stability and reduction. But these types of solutions and arguments and how we would contractually obligate those solutions from New York in relation to a solution was that type of federal capacity in a Maritz-based conversation about resolving some of these issues has not been allowed or not been readily available to the public in the mainstream media. And why is that? It's due to the improperly foreign bench trial monopolies of the type of immigration issues you have here and the value hyper protectionism, essentially same hyper protectionism, you see imposing upon the Council and the Mayor through Thrive New York City where people are being imposed upon to do or say one thing, but then

actually doing another. So it's rather disingenuous. So once we get over that hurdle and there is a more diverse conversation about solutions and where we are headed, then I feel like a majority of these issues, budgetary concern issues that are not directly related with your area of expertise, hospitals, but immigration and the collective will begin to resolve itself. Thank you.

CHAIRPERSON RIVERA: Thank you.

NAHAL ZAMANI: I was just going to and with regards to your previous question my organization, the Center for Constitutional rights, has been litigating against the NYPD for its stop and frisk practices for nearly 20 years and one thing that we found is that government agencies are super quick to disclose when they are discriminating against people's rights. Claims around not keeping data or arguing around practicability of reporting out, and that's not just for the NYPD. It's for many agencies, right? That engage in discriminatory behaviors. It's kind of an expected response. And so, no government agency is going to be specific as to how they are exercising discretion for the encounters that they are staff engage in with people

that actually have racially disparate impacts and have huge collateral consequences as they do in the case of ACS and H&H. But I urge the Council to reject these practicability arguments to compel reporting, to mandate through the authority that is granted to you to shed light on the practices and the impacts of these so-called interventions, which are not being made in the preservation of families and the promotion of their safety or their well-being or, factually, their dignity--

CASSANDRA FREDERIQUE: That's right.

NAHAL ZAMANI: but rather are and snaring them through criminalization and stigmatization. And so that's why intros 1161 and 1426 get it this. My fellow advocates and I, we are happy to enumerate particular additions and those reporting mechanisms that we think will get at the problem. But as the previous panel's testimonies show, this is the reality of people of color's lives. It's that they are being criminalized in every aspect. And so we are so grateful for this opportunity to shed light on the real roles of government actors and promulgating and furthering racism in the real oversight that you guys exercise

and power that you had to stop these horrible instances of family separation here in New York City from happening in the future. So thank you.

CHAIRPERSON RIVERA: Thank you so much for all that you do. I mean, I agree. I think the clear lack of definition and the-- you know, the path that the agencies have taken to create this ambiguity that only leads to anxiety and loss of wages, emotional trauma. There is so much that we have to do and I know that this package is a start. And you all been doing this work for a while and we owe you so much for leaving us in the right direction. So I look forward to continuing the conversation and seeing what else we can do with the Council, even if it's not legislation. It's just clearly bringing them to this table here and getting them on the record of all the things that they can't even tell us for sure. Which is absolutely unacceptable. So thank you. Thank you all. Thank you so much. And if there are no other members of the public who wish to testify-- seeing none. Going to adjourn this hearing. Thank you so much.

[gavel]

C E R T I F I C A T E

World Wide Dictation certifies that the foregoing transcript is a true and accurate record of the proceedings. We further certify that there is no relation to any of the parties to this action by blood or marriage, and that there is interest in the outcome of this matter.

Date May 9, 2019