Response to the report of the 51A Mandated Reporter Commission, seeking public comment.

March 25, 2021

By way of introduction, my name is Stephen C. Boos M.D. I am a board-certified child abuse pediatrician, professor of pediatrics at the University of Massachusetts Medical School – Baystate, and the co-medical director of the Family Advocacy Center at Baystate Children's Hospital in Springfield Massachusetts. I have been a pediatrician since 1983, have specialized in the evaluation of potentially abused children for more than 25 years, and have been a board-certified Child Abuse Pediatrician ever since such a certification existed. I have practiced in the U.S. Military, and in the states of California, Virginia, Maryland, New Jersey, and Massachusetts. From that experience, I bring the following observations on the commission's recommendations to the Massachusetts Legislature.

I have no responses to the many expansions in the definition of a mandated reporter. I will only note that there are states that have made all adults mandated reporters. That is a substantial change, with substantial ramifications, but I hope the Legislature will consider such a change in the future.

I was aware that the commission was considering changes to the section labelled "reporting responsibility" that do not appear to have been adopted. Specifically, I would recommend that contingency "(iii) physical dependence upon an additive drug at birth" requires modification. Many children are exposed to substances during pregnancy that have known or presumed long term harms, but do not produce dependence or withdrawal in the newborn period. These substances include legal and illegal drugs of abuse, including opiates, which do not always lead to neonatal abstinence syndrome. By contrast, prescribed opiates, for pain or for medically assisted abstinence therapy, may produce dependance and withdrawal. In many instances, it is the ongoing drug use, and associated social factors that are more important to the child's maltreatment experience and outcome than the in-utero exposure. As such, the issues of exposure and its setting are what is critical and the issue of dependence is irrelevant. I would recommend that the family of every child exposed to an illegal or intoxicating substance, in-utero, requires a thorough social assessment for ongoing risk and a remediation of that risk. Remediation may or may not involve removal of the child from the family. Under the current system, this goal is best accomplished by a report to and evaluation by DCF. Creation of an alternative is anticipated by the recommendations, but not elaborated in detail.

I strongly support the expansion of the reporting mandate to include substantial risk, above and beyond actualized injury.

The inclusion of sections defining abuse, neglect and sexual abuse is welcome. There are still ambiguities in terminology, such as what constitutes an injury and how much foreseeable risk, in what time frame, constitutes substantial risk. This ambiguity is likely best managed in implementation rules rather than the law. I would recommend a change in the last clause of the neglect definition. It is not possible for parents to "ensure" a child's safety, and it is not clear that safety alone assures medical, mental, and emotional well-being. I believe that the parents' duty is better expressed by reference to the community standard for meeting the child's needs, and would thus end the definition, "to provide minimally adequate food, clothing, shelter, medical care, supervision, emotional stability and growth, or other essential care to meet the child's needs." I also support the removal of the poverty exclusion, with the following comments. Whether neglect is the result of willful inaction, mental illness, substance use, ignorance, or poverty, the child's experience is the same. As such, all merit reporting and a response. Where poverty is the underlying etiology, however, the responsible parties extend beyond the parent. Often responsibility has a broad social basis. DCF has demonstrated to me that they understand this, and that this is dealt with in management. As such it need not be addressed in reporting.

The question of using the term "another" versus "caregiver" is a substantial one. In the neglect section, the use of the term "another" would make an incautious driver who harms a child by negligent driving practices reportable for neglect. Driving safely around children would be considered "essential care", and a lapse producing harm or risk would thus be neglect. Invoking the case of unknown perpetrators does not necessitate resorting to the term "another," as, by virtue of being unknown, the possibility that they are a caretaker is included. It may be better to resolve this issue by referring to "a person who is known to be, or who might possibly be a caretaker." Where the issue of the word "another" becomes more problematic is in the sections on abuse and sexual abuse. Removing reference to a caregiver immediately makes all cases of assault on a child into cases of abuse. Current law allows adults and children seeking care for sexual assault to consent or withold consent to notification of the authorities and submission of a sexual assault evidence kit. Those reporting assault have the right to submit that kit anonymously and claim it at a later date. Those reporting child abuse, however, must have DCF notified if they consent to a kit. Expanding the definition of abuse to include all "others" substantially expands the impact of these vagaries in the law. All cases of assault or sexual assault on a minor that come to medical attention will require reporting under this modification of the law, regardless of the assailant or the child and non-abusive family's preferences. Depending on the view of the provider regarding harm and risk, children coming to medical attention for care of sexually transmitted diseases, pregnancy or contraception might trigger an abuse report. Based on cross reporting law, this will make all these cases known to the District Attorney's Office. This is all equally true for a six-year-old and for a sixteen-year-old. For these reasons, I favor an expansive definition of "caregiver" and would advocate that this definition be put in law, but I oppose substitution of the

excessively broad word "other." Otherwise, the definition of what constitutes sexual abuse appears thoughtfully considered and well crafted, addressing the many particularities that come into assessing the likelihood of harm.

The definition of a "reasonable cause to believe" is also very welcome. This is, however, a very difficult task, as it references a mental state of the mandated reporter. In so doing, the entire construct does not demand a certain degree of preparation for fulfilling the roles of a mandated reporter; ignorance or lapse of awareness become legitimate defenses. Allusion to the word suspicion is an improvement, this word appears in many other state laws, and is commonly used in professional education on reporting mandates. I believe that reference to professional expertise and training is also an improvement, but I would reword this reference so that it holds professionals responsible for knowing the relevant body of knowledge for their profession. Wording the section, "or the mandated reporter's own observations or impressions as compared to their professional community's current consensus of opinion or science," requires professional reporters to reference the community standard and scientific state-of-the-art, rather than their own experience and opinion or that of a mentor. Appeal to the community consensus is important to counter fringe views or unproved hypotheses that circulate in professional communities.

I have no comment on the volunteers, penalties section or retaliation sections.

Consistent with my comments on a reasonable basis to believe being judged against community or scientific consensus on valid indicators of abuse suspicion, mandated training should extend beyond simple awareness of the reporting mandate and include profession appropriate training and re-training on when suspicion ought to occur. I presume that the proposal that training include, at a minimum, "indicators of child abuse and neglect" might be taken to indicate such a requirement but would like to see more specific language. Such training is complex, beyond the capacity of DCF, and should be funded.

The recommendations allude to, but do not provide language to address, issue with medical information sharing. The problem is a three-way interaction between practical needs in addressing suspected abuse and neglect, state reporting law, and the implementation rules of the Health Insurance Portability and Accountability Act (HIPAA). The most relevant section of those implementation rules are:

> *45CFR164.512(b)(ii) A covered entity may disclose protected health information for the public health activities and purposes described in this paragraph to a public health authority or other appropriate government authority authorized by law to receive reports of child abuse or neglect.*
>
> *45CFR164.512(c)(i) A covered entity may disclose protected health information about an individual whom the covered entity reasonably believes to be a victim of abuse, neglect, or domestic violence to a government authority, including a social service or protective services agency, authorized by law to receive reports of such abuse, neglect, or domestic violence to*

the extent the disclosure is required by law and the disclosure complies with and is limited to the relevant requirements of such law.

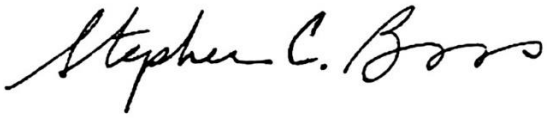
45CFR164.512(c)(iii) A covered entity may disclose protected health information about an individual whom the covered entity reasonably believes to be a victim of abuse, neglect, or domestic violence to a government authority, including a social service or protective services agency, authorized by law to receive reports of such abuse, neglect, or domestic violence when the disclosure is expressly authorized by statute or regulation and the covered entity, in the exercise of professional judgment, believes the disclosure is necessary to prevent serious harm to the individual or other potential victims.

45CFR164.512(c)(iii) A covered entity may disclose protected health information about an individual whom the covered entity reasonably believes to be a victim of abuse, neglect, or domestic violence to a government authority, including a social service or protective services agency, authorized by law to receive reports of such abuse, neglect, or domestic violence if the disclosure is expressly authorized by statute or regulation and the individual is unable to agree because of incapacity, a law enforcement or other public official authorized to receive the report represents that the protected health information for which disclosure is sought is not intended to be used against the individual and that an immediate enforcement activity that depends upon the disclosure would be materially and adversely affected by waiting until the individual is able to agree to the disclosure.

The main issue is with information sharing with law enforcement, including the district attorney's office. Current Massachusetts law uses permissive language, saying that mandated providers may report to law enforcement where appropriate. Permitted information sharing of protected health care information requires that a medical provider perceive that there is an ongoing threat of serious harm to the child or another person that can only be prevented by disclosure, or that a law enforcement activity requests the information and represents that failure to receive it would materially and adversely degrade an immediate enforcement activity. The later requirement also requires that the patient be unable to give consent, something that might rationally be assumed of a potentially abused minor. These issues are more problematic within the context of 51B than 51A, as 51B calls for greater information sharing. I do not advocate adding an additional mandate to report to law enforcement under 51A. A requirement to share information with law enforcement under 51B would solve the problem. Alternatively, encouraging greater DCF law enforcement collaboration and the formation of multi-disciplinary investigation processes would itself be beneficial. At that point, requiring mandated reporters to share information with the team and its individual members would overcome the HIPAA disclosure problems. Currently, law enforcement can overcome the HIPAA exception by making the representation referenced in the CFR, but they need to be trained to do this, and medical care providers need to be trained to recognize and respond appropriately to a proper request. A final problem is that 51B provisions end when a DCF investigation has been completed, eliminating provisions for communication of protected health care information

after this time. This can currently only be overcome by the consent of a guardian (including DCF) or by a subpoena. Because it would both facilitate communication of important healthcare information and encourage the best practice of joint DCF law enforcement investigation teams, I would recommend a modification to 51B requiring DCF, perhaps with conditions, to involve law enforcement early in an investigation and to require joint action between DCF and law enforcement in the ensuing investigation. I would also recommend a 51B mandate for mandated reporters and medical persons to share all relevant health care information with the multi-disciplinary investigation team and its individual members. I am content leaving the requirement for a release or subpoena after the investigation period.

Sincerely,



Stephen C. Boos, M.D.