Grayken Center for Addiction
Boston Medical Center

April 21, 2021

Mandated Reporter Commission
C/O Office of the Child Advocate
One Ashburton Place, 5th Floor
Boston, MA 02108

Submitted via email to mandated.reporter.commission@mass.gov

RE: Comments on Mandated Reporter Commission Status Report

Dear Members of the Mandated Reporter Commission,

Thank you for the opportunity to provide comments on the Mandated Reporter Commission Status Report.

We are writing on behalf of The Grayken Center and *Project RESPECT* at Boston Medical Center (BMC), a private, not-for-profit academic medical center located in Boston, Massachusetts. Established in 2017, The Grayken Center at Boston Medical Center serves as a national clinical resource in Addiction Medicine bringing evidence-based addiction treatments to our most vulnerable patients. The Center operates as the umbrella for all of BMC's work in addiction and is a national resource for revolutionizing addiction treatment and education, replicating best practices, and providing policy, advocacy and thought leadership to the field

Embedded within the OB/GYN Department at BMC, *Project RESPECT*, (**R**ecovery, **E**mpowerment, **S**ocial Services, **P**renatal care, **E**ducation, **C**ommunity, and **T**reatment) is the largest and longest standing, multidisciplinary program caring for pregnant and parenting persons with substance use disorders (SUD) in the commonwealth. Over the past 20 years, the *RESPECT* team has treated over 6,000 pregnant persons with substance use disorder and their newborns. We provide in-patient acute stabilization for pregnant persons with SUDs, offering immediate access to life-saving pharmacologic treatment for opioid and alcohol use disorder, immediate and barrier-free access to prenatal and mental health care, peer support, counseling, housing assistance and resource referrals. Pregnant persons who use drugs are desperate for help and terrified to ask; they fear judgement, punishment and loss of child custody. *Project RESPECT* team members strive to engage our patients with opioid use disorder and alcohol use disorder in evidenced-based pharmacotherapy (i.e. methadone, buprenorphine and naltrexone); these medications for opioid use disorder (MOUD) reduce the risk of overdose mortality by nearly 70%. Research has demonstrated the safety and efficacy of MOUD in pregnancy for both the mother and the infant, and yet based on Massachusetts' mandated reporting laws, any newborn born exposed to MOUD requires a 51A to be filed (suspected abuse or neglect) without consideration of maternal stability or child protective concerns.

Concerns with Section 51A(a): *(iii) physical dependence upon an addictive drug at birth, shall immediately communicate with the department orally and, within 48 hours, shall file a written report with the department detailing the suspected abuse or neglect*

We understand the vital importance of identifying children for whom protective concerns arise and the need for immediate response from state agencies to ensure safety and the protection of children from abuse or neglect. However, the current language requires reporting for any newborn exhibiting *physical dependence upon an addictive drug at birth,* which should not be used as a proxy to define child abuse or neglect. Medications prescribed for treatment of opioid use disorder when taken during pregnancy may result in a transient syndrome of withdrawal in the newborn (Neonatal Opioid Withdrawal Syndrome, NOWS). This syndrome is temporary, easily treated and expected. Women who are stable on MOUD prior to pregnancy *should not* stop this lifesaving medication if they become pregnant, however the fear of mandated reporting based on the expected NOWS syndrome often motivates treatment cessation. Women resist initiating MOUD in pregnancy and seek cessation of MOUD with the direct intention to avoid reflex 51A filing at delivery. The risk of overdose morbidity and mortality drastically increase with cessation of MOUD and disengagement in treatment.

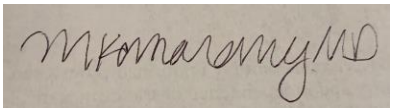
We urge the commission to consider changes to the language of the mandate shifting away from the type of intrauterine exposure and sequalae (i.e, *addictive drug, dependence*) and toward an objective assessment of protective concerns. The current language is imprecise (in utero exposure to an *addictive drug* does not equal *abuse or neglect*). Pregnant persons with conditions requiring pharmacologic treatment for which dependence and tolerance can develop should not be investigated for child abuse (i.e. Sickle Cell Disease, chronic neurologic injury, chronic pain syndrome, etc). Basing the investigation of child maltreatment on a medication prescribed during pregnancy serves only to alienate women from evidenced based medical treatments. If she accepts medically recommended and prescribed treatment for her disease which under the law is unfortunately perceived as a potentially *addictive drug*, she is forced to accept the mandate to be investigated for abuse and neglect of her unborn child. Pregnant persons who require such medical treatments should not have to face this dilemma. This commission can remove the dilemma by crafting language which encourages medical treatment without punitive mandates. Medical and legal teams can rely instead on the assessment, implementation and adherence to the Plan of Safe Care as an avenue for agencies and families to remain engaged in recovery care and maintain active assessment for child protective concerns.

The Plan of Safe Care mandate, required for all pregnant persons with SUD, will serve as the tool to assess child protective concerns and provide a structure to identify families who will benefit from the filing of a 51A. *Project RESPECT* has implemented facilitated multidisciplinary and live (virtual) Plan of Safe Care family meetings which bring together obstetric, pediatric, psychiatric, peer, behavioral health providers, and representatives from the Department of Children and Families with the family to create on-going child protective assessments and collaborative safety plans. We feel this type of assessment offers a thorough and on-going evaluation of family functioning, child safety and need for additional supports. This method of

inter-agency and family collaboration has proven to be successful in maintaining child safety and family unity.

We appreciate the opportunity to provide comments on the Mandated Reporter Commission Status report. We feel the Commission has the opportunity to dramatically improve the health outcomes of Massachusetts families, ensure evidenced-based assessments of child protective concerns and enhance interagency collaboration. We look forward to continuing to work with the Commission on these important issues related to helping our families in recovery.

Sincerely,



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