MASSACHUSETTS
MEDICAL SOCIETY
Every physician matters, each patient counts.

The Massachusetts Medical Society, representing more than 25,000 physicians, residents, and medical students, applauds the Mandated Reporter Commission (the Commission) for all their work, including producing this comprehensive report detailing proposed statutory changes to section 51A of chapter 119. We appreciate the opportunity to provide written comments on several of the proposed amendments, including the expansion of the definition of "medical provider" for purposes of who is a mandated reporter and reporting responsibilities for substance exposed newborns.

Definition of a Mandated Reporter – "Medical Provider" (p.12)

In further defining the term "mandated reporter" the Medical Society urges the Commission to consider the consequences of a large-scale expansion of who must report and realize the potential effect that could occur in exacerbating racial disparities.

Specifically, the Massachusetts Medical Society recognizes the critical role physicians and other medical providers play in identifying potential abuse and neglect in children and we support a robust approach to defining "medical provider" for purposes of the mandated reporter statute. As outlined in the report, it appears that the spirit of the proposed changes to the term "medical provider" is to expand the scope of medical personnel to any person who is licensed to provide emergency or nonemergency medical care. We also appreciate the need to expand the scope of medical providers who qualify as mandated reporters beyond a hospital setting and agree that the setting of medical care and treatment does not affect the information or insight a medical provider may learn during the course of such care or treatment.

The proposed change goes beyond medical personnel licensed to provide care by adding "personnel" who may be "engaged in" the "admission of…persons". This would capture administrative staff and would create an avenue for individuals who are untrained in the recognition and evaluation of potential abuse and neglect. While well-intentioned, persons without this critical training are generally not qualified to make such critical assessments, even with minimal basic training, and their reports may trigger unwarranted, misguided, and potentially harmful interventions – particularly for families of color. Moreover, we do not believe this is additive or helpful; in nearly any instance of an "admission" any child would have also engaged with several other medical professionals who would already have an obligation to report abuse or neglect under this law. It would be more prudent for non-medically trained persons who have concerns about abuse or neglect to report their opinions to persons on the care team with expertise in evaluating these questions for further consideration of reporting to DCF.

Lastly, we would note that an osteopath is a physician and does not need to be separately noted in the definition.

Reporting Responsibility: Substance Exposed Newborns (p.23-24)

The Medical Society believes that health care is a human right and strives for universal access to health care and nondiscrimination in health care settings for all people. We are invested in the Commission's mission to improve the response to, and prevention of, child abuse and neglect. As physicians, we are deeply committed to the health and well-being of pregnant people and children and also concerned about the many determinants of health of our patients. Throughout our nation's history, systemic and institutional power structures have created inequities and perpetuated and exacerbated negative health and social outcomes for people of color. This is particularly acute in the context of child protective services, which disproportionately impacts people and families of color.

The Massachusetts Medical Society recognizes the autonomy of all patients, including pregnant people, and opposes legislative interference in clinical decision-making when a person is found to have used or is using illicit or therapeutically prescribed narcotics during pregnancy. We recognize that pregnant people with substance misuse or abuse disorders generally require diagnosis and treatment for the benefit of mother and fetus. The MMS opposes the criminalization of substance use on the basis of pregnancy, including via the misuse of existing child endangerment or child abuse laws that were not intended for this purpose. As we strive for health equity, we are committed to finding solutions to the complex medical and social problems of substance abuse and advocating for vulnerable patients, especially during time periods most critical to their health such as the perinatal period.

The Medical Society has serious concerns about the current mandated reporting framework for substance exposed newborns and the harm it may cause to pregnant people and their families, which are outlined below. We appreciate the input the Commission has received relative to this perspective and the sub-working group created to address these very concerns. We understand the Commission's goal in mitigating these harms by proposing a dual-track reporting system for substance exposed newborns that creates an alternative pathway for certain reporting while keeping the Commonwealth compliant with federal child welfare reporting requirements. While we support the intent and of this dual-track reporting proposal, we also outline below concerns and considerations relative to how such proposed changes to the reporting framework would operate in practice.

Concerns with the Current Reporting Requirements for Substance Exposed Newborns

The current 51A mandated reporting requirements for substance exposed newborns tend to be interpreted strictly and as a result, may undermine harm reduction efforts and present barriers to patients seeking substance use disorder/opioid use disorder treatment. Child welfare reporting is shrouded in fear and stigma, which impacts decision-making during pregnancy for pregnant people with substance use disorder. Moreover, child welfare reporting has been well documented as a barrier and a deterrent to pregnant individuals seeking and receiving both prenatal care and treatment for substance use disorder; the patient-doctor relationship may be compromised, and quality of care may suffer, when patients cannot fully disclose problems of addiction or substance to their physician for fear of child welfare reporting or prosecution. Our physician members have shared countless stories of pregnant patients who have affirmatively decided to wean off their medication for opioid use disorder – which is evidence-based to treat pregnant people with OUD – to avoid a referral to DCF for fear of losing child custody, increasing the risk of harm for both the pregnant person and the fetus. Being "screened out" at DCF does little to provide any reassurance and the referral itself is stigmatizing enough to direct decisions that may not be in the best interest of their health and well-being overall.

Notably, there are several classes of medication taken during pregnancy, including antidepressants and benzodiazepines, which may impact the fetus and cause neonatal withdrawal symptoms requiring medical treatment at birth, but current guidance only requires 51A reports for medications to treat opioid use disorder, stigmatizing and discriminating against pregnant people with substance use disorder. Medical treatment decisions for substance use disorders should be made on an individual basis by patients in consultation with their physician and based on medical risks and benefits, as with any other chronic conditions, free from fear and stigma associated with child welfare reporting. Insofar as 51A reporting for substance exposed newborns deters pregnant people from accessing and continuing treatment, that is not in concordance with standards of care for OUD, and there is no data we are aware of to support a position that the use of prescribed medications for any medical condition, including SUD, is independently indicative of child abuse or neglect.

Such discrimination against pregnant people with OUD and their families is further exacerbated by racial disparities in maternal mortality and severe maternal morbidity. In Massachusetts, Black women die from pregnancy-related causes at twice the rate of White women and overall rates of pregnancy-associated mortality increased 33% from 2012 to 2014 alone.[1] Compounding this trend, Massachusetts and the nation are in the midst of an opioid use epidemic, which has only been intensified during the COVID-19 pandemic and is adversely impacting maternal health. A report from the Massachusetts Executive Office of Health and Human Services (EOHHS) found that more than a third (38.3%) of deaths among women delivering a live birth between 2011 and 2015 were fatal opioid-related overdoses.[2] This same report recommended further assessment of the impact of treatment engagement and retention on maternal overdose during the postpartum period and analysis to determine factors that may predict or protect against overdose among mothers in the first year postpartum. The state must do more to eliminate disparities and end stigma and discrimination harming pregnant people with OUD and enact policies that facilitate access to treatment and perinatal care.

Proposed Dual-Track Reporting System (p.23-24)

The Medical Society supports the spirit and framing of the proposed dual-track reporting system but has concerns about this approach and would like to raise issues for the Commission's consideration. Consistent with federal reporting requirements under CAPTA, a dual-track reporting system allows reporting of infants born exposed to substances, such as prescribed medication for opioid use disorder or prescribed chronic pain medication, which do not reach the standard of a mandated reporter's reasonable cause to believe a child is suffering or will suffer child abuse or neglect, to the Department of Public Health or some other state entity. This allows to the state to collect data as required by CAPTA through an alternative mechanism from the current system of child abuse and neglect reports. While it is a step in the right direction, we have concerns about how such a dual-track system would be implemented. Notably, for many pregnant people undergoing treatment for SUD/OUD, a report to the state – regardless of whether it is to DCF – is still stigmatizing and could still act as a potential deterrent to seeking or continuing treatment.

We cannot rectify racial inequities if we do not have the data that identifies those very disparities. Presuming this data is required to reported under CAPTA, we strongly support the proposal to anonymize aggregated data being sent to DCF from an alternative reporting pathway, and we would further urge the Commission to ensure that racial and ethnic data is collected and maintained for purposes of the alternative reporting pathway to ensure that we do

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[1] Massachusetts Department of Public Health, Maternal Mental Health & Pregnancy Associated Deaths, https://www.mass.gov/files/documents/2018/05/07/maternal-mental-health-data-brief.pdf.

[2] Massachusetts Department of Public Health. Legislative Report: Chapter 55 – An Assessment of Fatal and Non-fatal Overdoses in Massachusetts (2011-2015). Available at: https://www.mass.gov/files/documents/2017/08/31/legislative-report-chapter-55-aug-2017.pdf.

not perpetuate racial disparities. Since federally required, such reports to DPH would allow for epidemiologic evaluation to benefit public health and identify potential disparities in medical care associated with structural racial and ethnic inequities and as such, any report to DPH should therefore include this information while removing individual identifiers which could threaten patients. In the absence of racial, ethnic, and socioeconomic data for families being reported to DCF v. families reported through an alternative structure, we cannot know whether families of color are continuing to be disproportionately reported to DCF, perpetuating and systemizing racism that has and will continue to harm families of color in the Commonwealth if not addressed. The Commission should consider the utility of such data collection, especially considering that even an anonymous report to alternative state agency may still act as a barrier to care and treatment for pregnant people.

If the Commission moves forward with a dual-track reporting system, we urge further consideration of several important issues. First, there should be very clear criteria and risk factors for each reporting pathway, identifying what rises to the level of requiring a 51A report of suspected abuse or neglect, as opposed to a report to DPH. Such criteria should utilize objective, medicalized definitions for terms like recovery, stable recovery, or relapse if these concepts are going to be used to identify instances appropriate for an alternative pathway for reporting. Any 51A report submitted directly to DCF for investigation should be based on clinical information that substantiates whether or not there is evidence of abuse or neglect. A laboratory test alone (such as a toxicology screen) is insufficient to identify current or potential abuse or neglect and filing of a report triggered by this alone is more likely to result in harm than benefit. As the Commission considers the best option for safeguarding neonates and their mothers, input from clinicians with expertise in the evaluation of abuse and neglect is paramount.

Currently there are vastly differing interpretations of 51A requirements among institutions, and even different hospitals in the same system often screen and report differently; for example, some hospitals screen and automatically generate 51A reports for marijuana use, while others may screen but exercise discretion in reporting. We are concerned this discretion in screening lends itself to racial profiling and results in inequities, with families of color disproportionately reported to DCF. As the Commission's report notes, "children of color are over-represented at all stages of involvement with Child Protective Services, including the initial reporting stage."

While outside the scope of the legislative proposals before the Commission, we urge the Commission to work with the Department of Public Health (DPH) to amend elements of the "Guidelines for Community Standard for Maternal/Newborn Screening For Alcohol/Substance Use" issued by DPH in 2013.[3] Screening should be universal and testing should be based on defined and evidence-based criteria. Some criteria for urine testing outlined in current DPH guidance include: minimal or no prenatal care; unusual behavior; or a recent history of substance abuse or treatment in the past 5 years and/or currently on Medication Assisted Therapy (MAT) – the guidance notes that "participation in MAT does not always equal sobriety." The guidance further notes other risk factors which it says are considered to be "associated with substance use" such as history of physical abuse or neglect or mental illness. These criteria and associated risk factors are subjective, not necessarily evidence-based, and vulnerable to misapplication that may facilitate racial biases. Research in this area has evolved substantially since this guidance was issued and the Commission, in conjunction with DPH, should review

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[3] *See* https://www.mass.gov/doc/guidelines-for-community-standard-for-maternalnewborn-screening-for-alcoholsubstance-use-0/download

relevant literature and issue updated guidance with recommendations for evidence-based criteria for testing pregnant people and newborns. Further, the ethical principal of “respect for persons” requires that pregnant people give consent for testing, especially given the social and legal ramifications of the test. As such, there should be standard requirements for explicit informed consent for testing once eligibility criteria for testing are met.

Thank you very much for your time and your consideration of these issues. We appreciate the opportunity to offer these comments as you craft policy recommendations to improve the Commonwealth’s response to, and prevention of, child abuse and neglect. Should you have any questions or concerns, please do not hesitate to reach out to Leda Anderson, Legislative Counsel, at (781) 434-7668 or landerson@mms.org.