We submit this letter in response to the Mandated Reporter Commission's report on the prevention of and response to child abuse and neglect. We are a group of medical, public health, peer support and recovery professionals working with pregnant and parenting people in three rural Massachusetts counties.

We wish to emphatically share the following position with the commission: fetal exposure to prescribed medications for substance abuse disorder does not meet the criteria of child abuse and/or neglect and does not necessitate the filing of a 51A per mandated reporter requirements.
We write in support of the proposal under consideration by the commission (p.24) for a dual-track reporting system of de-identified data shared with DPH for federal reporting requirements, similarly proposed in Bill H.221, "An Act to Support Families".

Our experience is instructive of the following concerns, which we request the commission consider:

1. There is no useful distinction between the impacts of exposure to buprenorphine or methadone on an infant and other medicines that can contribute to neonatal abstinence syndrome, when considering the requirements of mandated reporting relative to child abuse and neglect.
2. Pregnant people are aware of reporting requirements and this causes people experiencing substance use challenges to eschew participation in MAT and other support programs.
3. The stressors of planning for and responding to 51A filing in the hospital are traumatic and harmful to the gestational parent/infant dyad. This is particularly impactful considering the evidence-based treatment protocol known as "Eat, Sleep, Console". This approach minimizes pharmacological intervention in favor of family connection and requires close observation of the infant by the parent(s) and the ability to respond to their needs calmly, quickly, and with the support of medical staff.
4. SAMHSA states that maintaining treatment with MOUD during pregnancy is best practice. Methadone and Buprenorphine are the safest medications to manage OUD in pregnancy. Both medications treat and prevent withdrawal symptoms, reduce opioid cravings and stabilize recovery. (SAMHSA Factsheet 2 "Treating Opioid Use Disorder During Pregnancy")
5. The current requirement to file a 51A for child abuse and neglect for babies born to pregnant people on MOUD stands in full opposition to best practice. Healthcare providers are put in the position to promote MOUD as best practice, and at the same time inform our patients that because they are on MOUD, we are obligated to file a 51A.This conflict contributes to further stigma and judgment and leads many pregnant people to stop their MOUD treatment placing them in danger of withdrawal, preterm labor and jeopardizing their recovery.

Signed:

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