Mandated Reporter Commission

September 15, 2020

Definition of Child Abuse and Neglect as it Relates to 51A

Current Text:

MGL c. 119 § 51A(a): A mandated reporter who, in his professional capacity, has reasonable cause to believe that a child is suffering physical or emotional injury resulting from: (i) abuse inflicted upon him which causes harm or substantial risk of harm to the child's health or welfare, including sexual abuse; (ii) neglect, including malnutrition; (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; or (iv) being a sexually exploited child; or (v) being a human trafficking victim as defined by section 20M of chapter 233.

110 CMR 2.00 (in part) definition of **neglect**: Neglect means failure by a caretaker, either deliberately or through negligence or inability, to take those actions necessary to provide a child with minimally adequate food, clothing, shelter, medical care, supervision, emotional stability and growth, or other essential care; provided, however, that such inability is not due solely to inadequate economic resources or solely to the existence of a handicapping condition. This definition is not dependent upon location {i.e., neglect can occur while the child is in an out-of-home or in-home setting.)

110 CMR 2.00 (in part) definition of **abuse**: Abuse means the non-accidental commission of any act by a caretaker upon a child under age 18 which causes, or creates a substantial risk of physical or emotional injury, or constitutes a sexual offense under the laws of the Commonwealth or any sexual contact between a caretaker and a child under the care of that individual. Abuse is not dependent upon location (i.e., abuse can occur while the child is in an out-of-home or in-home setting.)

Proposal for consideration based on Commission discussion:

MGL c. 119 § 51A(a): A mandated reporter who, in ~~his~~ their professional capacity, has reasonable cause to believe that a child is suffering, or at imminent risk of suffering, physical, mental, or emotional injury resulting from: (i) abuse inflicted upon ~~him~~ the child which causes harm or substantial risk of harm to the child's physical condition, health, or welfare, including sexual abuse; (ii) neglect, ~~including malnutrition~~ the inability to provide, or the deliberate or negligent failure or refusal to provide, a child with minimally adequate essential care, provided that any inability to provide such care is not solely due to inadequate economic resources or the existence of a disabling condition; (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.

A mandated reporter who, in their professional capacity, has reasonable cause to believe that a child is at risk of becoming, or has become, (iv) ~~being~~ a sexually exploited child; or (v) ~~being~~ a human trafficking victim as defined by section 20M of chapter 233; 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~~.

For purposes of this section "reasonable cause to believe" means that the mandated reporter's suspicion or belief is based on some verifiable information that a reasonable person in a like position would find pertinent to a child's physical, mental, or emotional well-being. "Reasonable cause to believe" does not require certainty, and can be based on observations, statements, impressions, and be informed by the particular training or experience of the mandated reporter. However, a violation of the law, without any indicia of harm or imminent harm to a child's physical, mental, or emotional well-being, does not, on its own, rise to the level of a "reasonable cause to believe" a child is suffering an injury as described herein.

Standardization Across Agencies

The OCA is not aware of any explicit definitions of abuse and neglect that differ from the DCF definition or formulation. However, other agencies run parallel investigations of abuse and neglect in order to 1.) determine whether there are licensing violations or concerns and/or 2.) to capture, investigate, and respond to incidents that may be unsupported by DCF or screened-out by DCF (due to the nature of the allegations or determination that the perpetrator is a non-caretaker). Some agencies have MOUs with DCF which determine how the agencies will coordinate investigations if both agencies will be investigation one incident or series of incidents.

1.) What complications arise when two agencies (or more) investigate one incident or series of incidents?

    a. What complications arise when an individual provider conducts its own internal investigation in addition to the agency level investigations?

2.) What complications arise when the two (or more) investigations reach conflicting conclusions?

3.) Do inter-agency MOUs resolve these complications? Could they resolve these complications? Would it be valuable to dictate that MOUs are necessary?

4.) What, if any, complications exist in the monitoring of, and response to, a concern that there was a failure to file a 51A? This can be determined as part of a licensing violation

or a determination or notation by DCF, and has consequences in the penalties section of the statute.

a. "…whoever violates [51A] shall be punished by a fine of not more than $1,000."

b. "Any mandated reporter who has knowledge of child abuse or neglect that resulted in serious bodily injury to or death of a child and willfully fails to report such abuse or neglect shall be punished by a fine of up to $5,000 or imprisonment…not more than 2 ½ years or both…upon a guilty finding or a continuance without a finding, the court shall notify any appropriate professional licensing authority of the mandated reporter's violation of this paragraph."

DESE does not have their own agency definition of child abuse and neglect. DESE regulations for program and safety standards for approved public or private day and residential special education schools prohibit any student being "…subjected to abuse or neglect, cruel, unusual, severe or corporal punishment…" (603 CMR 18.05(5)(e)).

- EEC references child abuse and neglect in MGL c. 15D § 9(c)
  - "The department shall promptly investigate and evaluate any notice transmitted to the department by [DCF] under subsection (l) of section 51B of chapter 119. Such investigation and evaluation shall determine whether the facility being operated by a person subject to licensure or approval under this section is being operated in compliance with this chapter and within the rules and regulations established under this chapter. If, during the course of any such investigation or licensing study conducted by the department, any agent or employee of the department receives or discovers information concerning the occurrence of child abuse or neglect, such agent or that employee shall make a report to [DCF under section 51A]."
- EEC regulations require that residential programs serving children and teen parents develop and follow procedures for conducting internal investigations within the program. Such procedures are to be used for suspected incidents of child abuse or neglect, "**including but not limited to incidents** within the program reported to [DCF] pursuant to …51A and shall be implemented upon request of the Department for any serious incident involving the health or safety of residents within the program" (emphasis added 606 CMR 3.04(3)(e)).
- EEC regulations for childcare programs include the following:
  - "Educators are responsible for abuse and neglect if:
    1. the educator admits to causing the abuse or neglect,
    2. the educator is convicted of the abuse or neglect in a criminal proceeding, or
    3. **the [EEC] determines, based upon its own investigation or an investigation conducted by the Department of Children and Families** subsequent to a report filed under…51A and 51B, that there is reasonable cause

to believe that the educator or any other person caused the abuse or neglect while the children were in care" (emphasis added 606 CMR 7.11(4)(c)).

- DMH regulations relating to the licensing and operational standards for mental health facilities includes that the facility shall notify DMH immediately, and in writing within one business day, of "any alleged abuse or neglect, or sexual or serious physical assault, which occurs between or among patients at the facility, or which occurs between or among patients and staff regardless of location, including any incident which is reported to another agency or law enforcement including, but not limited to:…51A…" (104 CMR 27.03(23)(h)(4)).
- DMH regulations create a reporting and investigation process (human rights investigation) for complaints regarding any "…incident or condition involving a client which he or she believes to be dangerous, illegal, or inhumane" (104 CMR 32.04(1)). There is a provision within this investigation process that indicates that the director of the program may "…defer an investigation to the Department of Children and Families, in which case he or she shall notify the Office of investigations" (104 CMR 32.04(6)(a)(2)).

Abuse of one child perpetrated by another child

Cases of sexual abuse or physical abuse committed by children against children are often screened-out of DCF involvement at the intake phase due to DCF regulations that identify that the definition of abuse or neglect for DCF purposes hinges on the alleged perpetrator being considered a "caretaker." These cases trigger mandatory referrals by DCF staff to district attorneys' offices under DCF policy (including cases of serious physical and sexual abuse). The 2018 criminal justice reform law raised the age of criminal responsibility proceedings from age 7 to age 12. The district attorney's office will often decline to take any prosecutorial action on these cases due to the age of the child who is the alleged perpetrator and other possible complications of bringing such cases.

Some of these cases are referred to a Child Advocacy Center (CAC) which provides a multidisciplinary team approach to child disclosures of allegations of sexual abuse, physical abuse, and witness to violence. The multidisciplinary team can include medical professionals, mental health professionals, law enforcement, DCF, and attorneys. CACs can be 501(c)(3) organizations (example: Bristol County), they can operate under the umbrella of a prosecutorial office or medical center, and though they can receive state funding, they are not subject to any uniform standards or procedures across the state. There is a National Network of Children's Advocacy Centers. Due to the variability of CAC models across the state, some CACs will accept cases of child sexual or physical abuse by an alleged child perpetrator and investigate those cases through a SANE interview or other means, and some CACs in the state will not accept such cases. This results in variability of response to these situations depending on geography.

The OCA in collaboration with the Children's Trust secured funding in the FY20 budget for an 18-month long pilot training program for Massachusetts CACs to address problematic sexual behaviors in children and youth. The pilot program is based on a University of Oklahoma training in Cognitive Behavioral Therapy for problematic sexual behaviors in children.

Other States' Formulations:

Florida: "Reports involving juvenile sexual abuse or a child who has exhibited inappropriate sexual behavior shall be made and received by the department. An alleged incident of juvenile sexual abuse involving a child who is in the custody of or protective supervision of the department shall be reported to the department's central abuse hotline.

1. The…hotline shall immediately…transfer the report…to the county sheriff's office. The department shall conduct an assessment and assist the family in receiving appropriate services…and send a written report of the allegation to the appropriate county sheriff's office within 48 hours after the initial report is made to the…hotline.

2. The department shall ensure that the facts and results of any investigation of child sexual abuse involving a child in the custody of or under the protective supervision of the department are made known to the court at the next hearing or included in the next report to the court concerning the child."

Rhode Island: "Any person who has reasonable cause to know or suspect that any child has been abused or neglected…or has been a victim of sexual abuse by another child, shall, within twenty-four (24) hours, transfer that information to the department of children, youth and families or its agent, who shall cause the report to be investigated immediately. As a result of those reports and referrals, protective social services shall be made available to those children in an effort to safeguard and enhance the welfare of those children and to provide a means to prevent further abuse or neglect."

Substance Exposed Newborns

The Child Abuse Prevention and Treatment Act (CAPTA) is a federal funding program with requirements for child protective service systems in multiple areas (intake, assessment, training, and so on). Starting in 2003, CAPTA has required that states have policies and procedures to address the needs of substance-exposed newborns (SENs). These policies and procedures must include appropriate referrals to child protective services and other appropriate services, and a requirement to develop a Plan of Safe Care for affected infants.

A Plan of Safe Care (POSC) is a plan developed to address the health and substance use disorder treatment needs of the infant and the affected family member/caregiver. The POSC must address the immediate safety needs of the newborn and should include appropriate services to stabilize the family. In Massachusetts, POSC are developed by a pregnant/parenting woman and a provider, and is a family service plan that addresses the parents' behavioral health and recovery services, including addiction and mental health supports, and child-focused services including specific medical services for the child and often a referral to early intervention.

POSC require coordinators who are responsible for creating and/or maintaining the POSC and connecting the family with the resources the plan details. Coordinators are often recovery coaches, case managers, early intervention staff, or medical providers. Any provider licensed by the Bureau of Substance Addiction Services, and their contracted providers, who have relationships with clients lasting longer than 30 days are required to ensure that their clients have a POSC. DPH has created a template for POSC in MA.

In Massachusetts, POSC are communicated to the hospital social worker before, or at, the time of delivery. If a POSC is not created in advance of the time of delivery, the hospital staff is responsible for creating the POSC after delivery. If the child is born affected by substance abuse, experiences withdrawal symptoms, or is affected by Fetal Alcohol Spectrum Disorder, the hospital files a 51A upon the birth of the child and communicates the existence of a POSC to DCF at that time. DCF then follows their process of screening-in or screening-out the report based on the information provided to them. If a child is not suffering any physical injury at the time of birth, POSC can be reported directly to DPH.

CAPTA requires that states report, among other things, the number of infants that are born affected by substance abuse or withdrawal symptoms or Fetal Alcohol Spectrum Disorder, the number of infants for whom a plan of safe care was developed, and the number of infants for whom a referral was made for appropriate services (including services for affected caregiver or family member). CAPTA requires that this reporting go to child protective services. However, the federal guidance is clear that although DCF should take the reports, gather the information, and report the numbers, CAPTA does not require that DCF treat these SEN reports as filings of allegations of abuse or neglect.

We understand section 106(b)(2)(B)(ii) of the Child Abuse Prevention and Treatment Act (CAPTA) to mean that health care providers must notify Child Protective Services (CPS) of all infants born and identified as affected by substance abuse, withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder. We do not believe that this provision requires the health care provider to refer such children and families to CPS as a report of suspected child abuse or neglect. Is this interpretation accurate?

Answer

Yes, this interpretation is accurate. CAPTA requires that the health care provider must notify CPS of *all* infants born and identified as affected by substance abuse, withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder. Such notification need not be in the form of a report of suspected child abuse or neglect. It is ultimately the responsibility of CPS staff to assess the level of risk to the child and other children in the family and determine whether the circumstance constitutes child abuse or neglect under State law. There may be Federal confidentiality restrictions for the State to consider when implementing this CAPTA requirement.

Children's Bureau Child Welfare Policy Manual Excerpt
https://www.acf.hhs.gov/cwpm/public_html/programs/cb/laws_policies/laws/cwpm/policy_dsp.jsp?citID=350

The CAPTA reporting requires POSC and data gathering for situations when a child is born "affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder." The word "illegal" was specifically removed from the term "substance abuse" in 2016. Despite the term substance *abuse*, the removal of the word "illegal," tends to suggest that CAFTA is attempting to capture the effects of substance *use*, or at least it will capture substance *use* regardless of intent.

Medical professionals have alerted the OCA that expectant mothers who are prescribed medication for opioid use disorder, including methadone and buprenorphine, have been weaning themselves from this prescribed medication prior to the birth of their children in order to avoid the filing of a 51A upon their child's birth. Medical professionals note that the decision to wean from these medications is based on the fear, founded or unfounded, of DCF involvement in their lives, rather than on the medical advice of their providers. For mothers who do not wean themselves from these medications, the filing of a 51A upon the birth of their child can add to the stigmatization of opioid use disorder and possibly contribute to the disproportionate DCF involvement of certain racial and ethnic groups. Even if the 51A is screened out, the prospect of DCF involvement, and the DCF record however confidential or minimal, likely has a strong effect on expectant mothers taking prescribed medications that will be present in their babies' systems upon birth. One peer reviewed study noted that "Seventy-five percent of women [in the study] who chose to discontinue methadone or buprenorphine expressed concern about the potential involvement of the Department of Social Services as well as how they would be viewed by medical staff during delivery…"[1]

[1] Guille, C., Jones, H. E., Abuhamad, A., Brady, K. T. (2019). Shared decision-making tool for treatment of perinatal opioid use disorder. *Psychiatric Research and Clinical Practice 1*(1): 27-31. doi: 10.1176/appi.prcp.20180004.

Several of our neighboring states have created a statutory pathway separate from abuse and neglect filings to permit the filing of CAPTA information (POSC and data requirements) using non-personally identifiable information.

Connecticut has an online portal for the filing of abuse and neglect reports as well as what they consider to be CAPTA "notifications." The online portal requires responses to prompted questions, those answers determine whether the report is categorized as an allegation of child abuse or neglect, or whether it is a CAPTA notification. If the report is a CAPTA notification, then no personally identifiable information is gathered by the department and only the data needed for federal reporting and ensuring POSC are in place are reported.[2]

Rhode Island permits reporting of POSC to their Department of Health instead of DCF when there are no concerns of child abuse and neglect and (1) the mother is engaged in medication-assisted treatment for substance use disorder, (2) mother is taking opioids as prescribed, or (3) mother is taking other medication(s) as prescribed. The Department of Health compiles the data for the POSC and transmits that data quarterly to the Department of Children, Youth and Families (DCYF) for federal reporting purposes.[3]

- Notably, DCYF has a hospital alert system when DCYF becomes aware of pregnant women for whom there may be a potential child safety concern after birth. This is often when DCYF receives reports of pregnant women who are abusing drugs or alcohol during their pregnancy. DCYF will only initiate an investigation if there are children living in the pregnant woman's home, if not, the hospital will be alerted of the concerns and no investigation will ensue. Hospitals are notified if, (1) there is a known history of chronic substances use by one or both parents, (2) when both parents have a history of child abuse/neglect, (3) when one or both parents has a child abuse/neglect conviction, (4) there are concerns about the safety of the child after delivery.

This notification process may in some way serve as a type of pre-screening that DCYF can provide prior to the birth of an infant that may potentially lead a medical provider to file a report of child abuse and neglect rather than filing the POSC with the Department of Health. It provides some context in the way a DCF history may provide at the time of screening in Massachusetts.

Vermont has a two track system as well, one track for reporting child protection concerns, and one track for notifying DCF when a newborn is prenatally exposed to substances but there are no child protective concerns- that notification does not contain identifying information of the mother/child/family. Vermont has identified the following situations to be suitable for the notification track: (1) mother is stable and engaged in medication-assisted treatment with methadone or buprenorphine, (2) mother is being treated with opioids for chronic pain by a physician, (3) mother is taking benzodiazepines as prescribed by her physician, (4) newborn was prenatally exposed to marijuana. Vermont notes that any marijuana use that causes concern for

[22] For further information: https://portal.ct.gov/DMHAS/Programs-and-Services/Women/CAPTAPlan-of-Safe-Care, https://portal.ct.gov/-/media/DMHAS/womenservices/UnderstandingCAPTApdf.pdf

[3] Additional information available at: http://www.dcyf.ri.gov/documents/POSC-Guidance-FINAL-060818.pdf

the parent's ability to care for the child would cause a child protective concern and would prompt a report.[4]

New Hampshire also has a two track system, one track for reporting concerns of child abuse or neglect, and the other track for notification of infants born affected by prenatal drug or alcohol use. The hospital fills out a "birth certificate worksheet" that captures the information needed to aggregate the data on prenatal substance exposure for federal reporting. The Department of Public Health will de-identify and aggregate the data and provide it to DCYF for the purposes of federal reporting. New Hampshire does specify that POSC must be provided to DCYF if the hospital does file a child abuse or neglect report upon birth.[5]

New York does not have a two track system for reporting information solely related to SEN, but rather has a two track system for all child protective cases. Cases are either placed on the track of CPS investigation, or a differential response system called family assessment response. Family assessment response is an alternative means of responding to reports of neglect which permits ongoing assessment of safety without requiring a determination on whether the reported abuse or neglect occurred (supported)- "The family assessment response approach seeks to minimize future risk of abuse or maltreatment of a child or children by engaging the family in the development and implementation of solution-focused plans to address identified needs in order to support the family's ability to care for its children."[6] The POSC guidance encourages the use of the family assessment response for substance exposed newborns- noting that "…CPS should consider whether a [family assessment response] assignment for a report received involving substance abuse most effectively supports the safety of child(ren) named in the report and matches the family's needs."[7]

Massachusetts:
The DCF screening process for SEN includes a review of the available records on the caregiver which includes screened-in reports as well as screened-out reports. This historical background provides DCF with context that a hospital or medical provider may not have on an individual or family. This context may elevate concerns for the child's safety in the parents'/caregivers' care and result in the screening-in of reports that may, on the surface, appear to not warrant a heightened concern for child abuse or neglect. Therefore, the designation of the 51A process as the mechanism to gather the necessary POSC data for the state and for CAPTA reporting identifies a vulnerable population of children, newborns experiencing physical effects from substance use, and uses the tools available only to DCF screeners to determine the risk to this population.

If DCF were to employ the two-track system, 51A reporting for situations where the medical providers felt the concern rose to the level of reasonable cause to believe the child suffered (or

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[4] More information available at: https://dcf.vermont.gov/sites/dcf/files/FSD/Docs/CAPTA-FAQs.pdf
[5] More information available at: http://1viuw040k2mx3a7mwz1lwva5-wpengine.netdna-ssl.com/wp-content/uploads/2019/08/FINAL_POSC_ProviderLetter_7-15-19.pdf, https://nhcenterforexcellence.org/governors-commission/perinatal-substance-exposure-task-force/plans-of-safe-care-posc/
[6] 18 CRR-NY 432.13 available at: https://govt.westlaw.com/nycrr/Document/I913a5f015f5811e48b080000845b8d3e?viewType=FullText&originationContext=documenttoc&transitionType=CategoryPageItem&contextData=(sc.Default)&bhcp=1
[7] https://ocfs.ny.gov/main/policies/external/OCFS_2017/LCMs/17-OCFS-LCM-03.pdf

was at imminent risk of suffering) from child abuse or neglect, and a separate reporting mechanism for anonymous data collection of POSC for state purposes and for purposes of CAPTA reporting, then DCF screeners would not have the ability to provide historical context to the present concerns facing the SEN. However, this situation appears to be the only one in which the mandated reporter is not required to determine in their own professional capacity whether there is reasonable cause to believe there is concern enough to warrant a 51A report. There are other vulnerable populations of children that are not provided this historical context lens as the mandated reporter bringing the issue to DCF's attention does not have that lens to apply. Singling out SEN as requiring a screening decision regardless of the concern, or lack thereof, of the mandated reporter risks stigmatizing opioid use disorder even when the mother or caregiver is following medical advice and taking only prescribed medication, risks disproportionately involving certain racial and ethnic groups with DCF involvement, and creates a dangerous situation in which some mothers choose to forego their prescribed medications close to the birth date of their child in order to avoid DCF involvement – this is spurred in part by the distrust that DCF will appropriately screen-out cases if there is no concern for child abuse and neglect.

Possible Statutory Language:

MGL c. 119 § 51A(a): A mandated reporter who, in ~~his~~ their professional capacity, has reasonable cause to believe that a child is suffering, or at imminent risk of suffering, physical, mental, or emotional injury resulting from: (i) abuse inflicted upon ~~him~~ the child which causes harm or substantial risk of harm to the child's physical condition, health, or welfare, including sexual abuse; (ii) neglect, ~~including malnutrition~~ the inability to provide, or the deliberate or negligent failure or refusal to provide, a child with minimally adequate essential care including adequate medical care and/or adequate care in light of a caregiver's substance use or abuse, provided that any inability to provide such care is not solely due to inadequate economic resources or the existence of a disabling condition; ~~(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.

A mandated reporter who, in their professional capacity, has reasonable cause to believe that a child is at risk of becoming, or has become, (iv) ~~being~~ a sexually exploited child; or (v) ~~being~~ a human trafficking victim as defined by section 20M of chapter 233; 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~~.

A mandated reporter who becomes aware that a child has been born affected by substance use or abuse, withdrawal symptoms, or Fetal Alcohol Spectrum Disorder, must file a report in accordance with this section. If there is a Plan of Safe Care in place, and such Plan of Safe Care has been reviewed by the mandated reporter, and the mandated reporter has no concern that the child is suffering from, or at imminent risk of suffering from, abuse or neglect as described in this section, the mandated reporter may file a report in the manner described herein excepting

that the mandated reporter will not be required to provide any personally identifying information of the mother or the child to DCF for reporting purposes.

For purposes of this section “reasonable cause to believe” means that the mandated reporter’s suspicion or belief is based on some verifiable information that a reasonable person in a like position would find pertinent to a child’s physical, mental, or emotional well-being. “Reasonable cause to believe” does not require certainty, and can be based on observations, statements, impressions, and be informed by the particular training or experience of the mandated reporter. However, a violation of the law, without any indicia of harm or imminent harm to a child’s physical, mental, or emotional well-being, does not, on its own, rise to the level of a “reasonable cause to believe” a child is suffering an injury as described herein.