



ACLU of Massachusetts
One Center Plaza, Suite 850
Boston, MA
www.aclum.org

September 26, 2023

Joint Committee on Children, Families, and Persons with Disabilities
Sen. Robyn Kennedy & Rep. Jay Livingstone

**Support for S.64 & H.173
An Act to Support Families**

Chair Livingstone, Chair Kennedy, and Members of the Committee on Children, Families, and Persons with Disabilities:

Thank you for your ongoing commitment to improving the lives of children and families across the commonwealth. Like you, we believe the child welfare system must center around the best interests of the child and serve specifically as a harm reduction mechanism for children in Massachusetts. *An Act to Support Families* would further this goal by enabling doctors to make individualized assessments regarding prenatal substance use exposure instead of mandating that they file non-evidence-based 51A reports in every case. The committee gave this legislation a favorable report last session, and we ask that you advance it again and help shepherd it into law.¹

Unfortunately, Massachusetts law about pregnancy and substance use is outdated and draconian. It paints with an overly broad brush, labeling all prenatal exposure to an “addictive drug” as child abuse. As such, the law is not rooted in science or child and family welfare, conflicts with the advice and best practices of leading medical organizations, and causes severe harm to families throughout the Commonwealth. *An Act to Support Families* would update the law to center the best interests of the child and bring Massachusetts policy in this area in line with the rest of New England.

¹ We also want to acknowledge important related legislation, H.166 and S.129. We prefer the simplicity of *An Act to Support Families*, and we particularly want to avoid replacing the existing broad mandatory reporting requirement with a new and potentially confusing, albeit narrower, mandate under 51A. However, we deeply appreciate the spirit of these proposals. We would welcome the opportunity to work with the Committee to refine and advance any of the proposed legislation before you on this subject.

Under current Massachusetts law, the birth of a substance-exposed newborn triggers an automatic obligation on healthcare providers to report the birth parent to the Department of Children and Families (DCF). This report, referred to as a 51A report, initiates an invasive screening process into the birth parent's life and is mandated *regardless of whether the substance was prescribed to the pregnant individual for addiction treatment or whether the healthcare provider believes a report is warranted*.

This conflicts with the medical consensus—recognized by organizations including the American College of Obstetricians and Gynecologists, the World Health Organization, the Substance Abuse and Mental Health Services Administration, and the Massachusetts Department of Public Health—that for pregnant people with opioid use disorder, MOUD (medication for opioid use disorder) is the standard of care and the safest course of action for the pregnant person and the child. Current Massachusetts law forces a pregnant person with substance use disorder to make an impossible, and dangerous, choice: either they can continue treatment, which is in the best of interest of their own health and the health of their pregnancy, knowing that their provider will be forced to file a 51A report at the birth of their child, or they may try to stop treatment, which presents many health risks to the pregnant person and the fetus, in an attempt to avoid a 51A report and the invasive screening that follows. This is a clear instance of the state inappropriately inserting itself into the doctor-patient relationship.

An Act to Support Families makes two straightforward and important updates to the 51A statute, bringing the Commonwealth in line with current best practices to support the best interests of newborns and their families.

First, the bill eliminates “physical dependence upon an addictive drug at birth” from the definition of per se child abuse and neglect. This outdated definition directly and automatically connecting substance exposure with child abuse and neglect is not grounded in science. Leading medical groups agree that prenatal exposure to substances can be treated and is not automatically bad; in fact, when the birth parent is being treated with MOUD for substance use disorder, this exposure is critically important for the best interests of the child that the birth parent remain in recovery during and after pregnancy. Under the proposed bill, healthcare providers would still have the obligation to file a 51A report when they have an actual concern of abuse or neglect, but the singular fact of prenatal exposure would not automatically trigger a report.

Second, the bill clarifies the Commonwealth's obligation to collect de-identified data about substance exposed infants without requiring reporters to file a 51A report based on substance exposure when there are no concerns of abuse or neglect. The invasive screening process mandated under current Massachusetts law goes beyond what is required by the

federal law under the Comprehensive Addiction and Recovery Act (CARA) amendments to the Child Abuse Prevention and Treatment Act (CAPTA), and is out of step with medical best practices. This legislation would update Massachusetts law to create a “dual-track” reporting system, similar to the systems our New England neighbors use to implement CAPTA/CARA. Under a dual-track reporting system, providers would still be required to submit abuse and neglect reports regarding substance-exposed newborns when they have an actual concern of abuse and neglect, but in all other instances involving substance-exposed newborns, providers would transmit de-identified information to DCF for inclusion in federal reports.

Massachusetts’ draconian reporting requirements are not in the best interest of the child and perpetuate racial inequality

Current reporting requirements are a harmful relic of the failed War on Drugs, built on racially derogatory narratives that tied society’s ills to drug use by Black mothers. Further entrenching this framework, the federal government passed laws that incentivized states to adopt similarly harmful policies by committing unprecedented funds into reimbursing states for the costs of separating families through legislation such as CAPTA, while decreasing available state funds for basic necessities such as health care – including mental health and drug treatment – and housing and childcare.² The resulting laws institutionalized these discriminatory narratives within social and child welfare systems by using child protection to justify the hyper-surveillance of poor and drug addicted mothers and to implement punitive policies that tied drug use to child neglect.³ One such example is the rapid expansion of state laws surveilling pregnant people like the section of the 51A statute this legislation would reform.

By requiring 51A reports for the mere fact of prenatal substance exposure, the existing Massachusetts law stigmatizes pregnant people with substance use disorders. It puts families through stress -- which can hurt the pregnancy -- at the very moment that families should be focused on nurturing a healthy pregnancy and bonding with their infant. Even when a 51A report does not result in allegations of child abuse or neglect by DCF, the screening process itself is intrusive and harmful. DCF often speaks to family members, who in some instances may not have previously known that the pregnant person was in recovery, and requires people to release their addiction treatment information.

² See generally, Lisa Sangoi, “Whatever they do, I’m her comfort, I’m her protector.” How the Foster System Has Become Ground Zero for The U.S. Drug War, Movement for Family Power, June 2020.

³ An infant born with prenatal substance exposure is not predictive or determinative of the birth parent’s fitness to parent, particularly because in many cases new mothers are being reported to DCF for drugs prescribed to them as part of addiction treatment they sought out during their pregnancy. U.S. Department of Justice, A National Report from the Bureau of Justice Statistics (Dec. 1992), NCJ-133652 at 119.

At the same time that the American College of Obstetricians and Gynecologists *recommends* treatment with MOUD for pregnant people with opioid use disorder, the existing Massachusetts law tells pregnant people that they will be reported to DCF if they receive such treatment. These conflicting messages can create insurmountable hurdles to entering into and continuing treatment, putting both the pregnant person and the fetus in danger. This harms new parents and newborns by undermining trust in the doctor-patient relationship, and thereby deters pregnant people from seeking essential prenatal healthcare or substance use disorder treatment during their pregnancies, two measures known to improve the outcomes for infants born to individuals who use drugs.⁴ Indeed, leading medical groups like the American Medical Association and the American Academy of Pediatrics have long opposed laws that punish women who seek treatment precisely because such laws discourage women from seeking necessary care in the first place.

Whatever harms flow to families from increased state intrusion are borne disproportionately by children and parents of color. Despite the fact that drug use by Black and white women occurs at approximately the same rate in the U.S.,⁵ studies show that nationally Black mothers are more likely than white mothers to have been screened for drugs at the birth of a child.⁶ And there is no reason to believe that the Commonwealth is immune from these disparities. As a recent draft report by the Mandated Reporter Commission notes, “children of color are over-represented at all stages of involvement with Child Protective Services, including the initial reporting stage.”⁷

An Act to Support Families aligns the Commonwealth’s implementation of federal law with other New England states

⁴ American College of Obstetricians and Gynecologists, Committee Opinion 633, Alcohol Abuse and Other Substance Use Disorders: Ethical Issues in Obstetric and Gynecologic Practice (June 2015).

⁵ U.S. Dept. of Health & Human Services, Results from the 2013 National Survey on Drug Use and Health Summary of National Findings (2014), <https://www.samhsa.gov/data/sites/default/files/NSDUHresultsPDFWHTML2013/Web/NSDUHresults2013.pdf>.

⁶ Chasnoff, Ira J., Harvey J. Landress, and Mark E. Barrett. 1990. "The Prevalence of Illicit-Drug Or Alcohol use during Pregnancy and Discrepancies in Mandatory Reporting in Pinellas County, Florida." *New England Journal of Medicine* 322 (17): 1202-1206. doi:10.1056/NEJM199004263221706; Ellsworth, Marc A., Timothy P. Stevens, and Carl T. D'Angio. 2010. "Infant Race Affects Application of Clinical Guidelines when Screening for Drugs of Abuse in Newborns." *Pediatrics* 125 (6): e1379-85. doi:10.1542/peds.2008-3525; Race Tilt in Foster Care Hit; Hospital Staff More Likely to Screen Minority Mothers, *Daily News of Los Angeles* (June 29, 2008), available at <http://advocatesforpregnantwomen.org/LA%20daily%20news%20series.pdf>; Roberts, Sarah C., and Amani NuruJeter. 2010. "Women's Perspectives on Screening for Alcohol and Drug use in Prenatal Care." *Women's Health Issues* 20 (3): 193-200. doi:10.1016/j.whi.2010.02.003; Rotzoll, Brenda W. "Black Newborns Likelier to be Drug Tested: Study." *Chicago Sun-Times*, March 16, 2001; Anderson, Troy. "Race Tilt in Foster Care Hit; Hospital Staff More Likely to Screen Minority Mothers." *L.A. Daily News*, June 30, 2008.

⁷ Massachusetts Mandated Reporter Commission, "Mandated Reporter Commission Final Report" (June 2021), found at: <https://www.mass.gov/doc/mandated-reporter-commission-final-report-63021/download>

Originally enacted in 1974, CAPTA provides federal funding to states to support the “prevention, assessment, investigation, prosecution, and treatment” of child abuse, in exchange for states’ fulfillment of certain requirements.⁸ In the last twenty years, Congress has amended CAPTA to impose new requirements on states to implement policies that “notify” child welfare agencies of babies who fall into one of the three enumerated categories: being “affected by substance abuse”, affected by withdrawal symptoms resulting from prenatal drug exposure” or having Fetal Alcohol Spectrum Disorder.⁹

The federal law neither requires child protective reports or identifying information, nor does it require hospitals to drug test pregnant people. Indeed, the federal law’s plain language makes clear that CAPTA/CARA notifications “shall not be construed to establish a definition under Federal law of child abuse or neglect.”¹⁰ It is therefore not surprising that many states, including all other New England states, implement the federal law without requiring automatic reports to DCF for the singular fact of prenatal substance exposure. Connecticut, Maine, New Hampshire, and Vermont do not include prenatal substance exposure in their definitions of child abuse or neglect. And while Rhode Island requires reporting when an infant has withdrawal symptoms resulting from prenatal exposure, Rhode Island does not require reporting simply on the basis that an infant was prenatally exposed to MOUD. Massachusetts is the *only* state in New England that requires healthcare providers to automatically report a person to DCF for suspected abuse or neglect whenever they give birth to an infant who was prenatally exposed to an “addictive drug,” including medications prescribed for addiction treatment.

The punitive aspects of the Commonwealth’s current reporting practices increase the likelihood of unnecessary family separation and threaten the health and wellbeing of both mothers and newborns, and these harms will disproportionately be borne by families of color. The current mandated reporting obligations on healthcare workers undermine the trust that is critical to ensuring positive health outcomes for both infants and their parents. The proposed bill centers the best interests of the child by obligating healthcare providers to file a 51A report only when they have an actual concern of abuse or neglect without unnecessarily subjecting birth parents and their newborns to unwarranted state surveillance and the accompanying harmful consequences to them and their families. We urge you to give *An Act to Support Families* a favorable report.

⁸ 2 U.S.C. § 5106; U.S. Dep’t of Health and Human Services, Admin. For Children and Families, About CAPTA: Legislative History (July 2011), found at: <https://www.childwelfare.gov/pubPDFs/about.pdf>.

⁹ *Id.*

¹⁰ 42 U.S.C. § 5106a(b)(2)(B)(ii).