



# MASSACHUSETTS MEDICAL SOCIETY

*Every physician matters, each patient counts.*

**TESTIMONY IN SUPPORT OF H.173/S.64  
AN ACT TO SUPPORT FAMILIES  
BEFORE THE JOINT COMMITTEE ON CHILDREN, FAMILIES AND PERSONS  
WITH DISABILITIES  
September 26, 2023**

**The Massachusetts Medical Society wishes to be recorded in support of  
H.173/S.64, *An Act to support families.***

The Massachusetts Medical Society is a professional association of over 25,000 physicians, residents, and medical students across all clinical disciplines, organizations, and practice settings. The Medical Society is committed to advocating on behalf of patients, to give them a better health care system, and on behalf of physicians, to help them provide the best care possible. The MMS strives for health equity, advocating for vulnerable patients especially during time periods most critical to their health. Accordingly, and for the reasons below, we support H.173/S.64, which would reform 51A mandated reporting policies for substance exposed newborns, as child welfare reporting has been well documented as a barrier and deterrent to pregnant individuals seeking and receiving both prenatal care and treatment for substance use disorder (SUD). This legislation is an important step toward rectifying racial inequities and discrimination in our child welfare reporting system and our health care system.

The Massachusetts Medical Society has serious concerns about the current mandated reporting framework for substance exposed newborns under Chapter 51A of the general laws, which conflicts with the advice and best practices of leading medical organizations and ultimately harms pregnant people and their families. This legislation 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. First and foremost, the current law on pregnancy and substance use interferes with the doctor-patient relationship and undermines recovery. Mandated reporting requirements for substance-exposed newborns are interpreted rigidly, imposing an automatic obligation on health care providers to report the birthing parent to the Department of Children and Families

(DCF). This practice not only undermines harm reduction efforts but also creates barriers for patients seeking treatment for substance use disorder. Complicating matters further, while the American College of Obstetricians and Gynecologists recommends medication for opioid use disorder (MOUD) for pregnant individuals with opioid use disorder (OUD), existing Massachusetts law requires reporting to DCF if patients opt for such treatment. These conflicting messages can create daunting obstacles to initiating and sustaining treatment, endangering both the pregnant individual and the fetus.

Child welfare reporting casts a shadow of fear and stigma, influencing decision-making for pregnant individuals grappling with substance use disorder. Documented extensively as a barrier, child welfare reporting deters pregnant individuals from seeking prenatal care and substance use disorder treatment. This fear impedes open communication between patients and health care providers, compromising the patient-doctor relationship and quality of care. Many physicians can recount numerous instances where pregnant patients opted to taper off MOUD, despite its evidence-based efficacy, to evade DCF referrals and potential loss of child custody, heightening risks for both the individual and the fetus. Even if "screened out" by DCF, the mere referral perpetuates stigma and influences decisions that may not align with the individual's overall health and well-being. Notably, esteemed medical organizations like the American Medical Association and the American Academy of Pediatrics have staunchly opposed punitive laws targeting pregnant patients seeking treatment, recognizing their detrimental impact on healthcare access and outcomes.

Medical treatment decisions for SUD should be patient-centered, meaning that they should be personalized, made collaboratively between patients and their health care providers, and rooted in an evaluation of medical risks and benefits, akin to managing any other chronic condition. These decisions should be shielded from the fear and stigma associated with child welfare reporting. The deterrent effect of 51A reporting on pregnant individuals seeking and sustaining treatment runs counter to the established standards of care for OUD. Moreover, there exists no data to substantiate the assertion that the utilization of prescribed medications for any medical condition inherently signifies child abuse or neglect.

Harm to pregnant people with OUD and their families is further exacerbated by racial disparities in maternal health outcomes. In Massachusetts, the prevalence of severe maternal morbidity (SMM) nearly doubled in Massachusetts from 2011 to 2020, with Black non-Hispanic

birthing people consistently experiencing the highest rates of labor and delivery complications among all races and ethnicities.<sup>1</sup> This troubling trend is compounded by the ongoing opioid use epidemic in Massachusetts and nationwide, which is significantly impacting maternal health. According to a report by the Massachusetts Department of Public Health, between 2011 and 2020, for every 10,000 deliveries, there were 113.1 deliveries with SMM among people with OUD.<sup>2</sup> The current 51A reporting structure acts as a deterrent for individuals seeking treatment with their health care providers, thereby exacerbating racial disparities in untreated health issues and maternal mortality and morbidity. It is imperative that we take decisive action to eliminate these disparities, eradicate stigma and discrimination, and implement policies that facilitate access to treatment and perinatal care for pregnant individuals with OUD.

This legislation 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 and harms child, maternal, and family health. Leading medical groups agree that prenatal exposure to substances can be treated and is not automatically harmful; 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, health care 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.

Without the threat of a mandatory report of abuse for taking medically indicated medication, more pregnant people with substance use disorder will be comfortable seeking necessary prenatal care and maintaining their evidence-based treatment, leading to overall improvements in maternal and infant health outcomes. We therefore urge a favorable report on this legislation. Thank you for your consideration.

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<sup>1</sup> Data Brief: An Assessment of Severe Maternal Morbidity. Massachusetts Department of Public Health. 2023. <https://www.mass.gov/doc/an-assessment-of-severe-maternal-morbidity-in-massachusetts-2011-2020/download>

<sup>2</sup> Ibid.