MEDICAL LEGAL PARTNERSHIPS AND CHILD WELFARE: AN OPPORTUNITY FOR INTERVENTION AND REFORM

Kara R. Finck*

I. INTRODUCTION

Between navigating her son's medical appointments and the repeated calls from school that he was acting out in his fifth-grade classroom, Mrs. Ago was feeling increasingly stressed and overwhelmed.[1] Her oldest son was struggling in school, acting out, and losing his control with the teachers. Although she had asked for help, he was not receiving enough support in school to control his behavior or improve his grades in math. She couldn't help him with his homework, having never learned to read or write in her native language and still struggling to learn to speak English. The teachers reiterated that she should spend more time with him on his homework, but she was too ashamed to disclose her own illiteracy. Ultimately, the school called the local child welfare agency and caseworkers questioned Mrs. Argo about all of her children, her son's medical conditions, and why he had visited so many different hospitals and emergency rooms. When a notice came that her son's SSI benefits decreased and the electricity bill was increasing, she had no idea where to turn for help and which crisis to address first.

After a visit to the Children's Hospital of Philadelphia's (CHOP) emergency room, Mrs. Ago received a screening instrument as part of the packet of release forms to sign, but this one asked if she had any legal needs and wanted to speak with a lawyer. Responding affirmatively, she was connected to a new model of

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* Practice Professor of Law and Director, Interdisciplinary Child Advocacy Clinic, University of Pennsylvania Law School. I want to acknowledge and thank Martha Raimon from the Center for the Study of Social Policy for her tremendous insight and support in developing this article.

[1] For confidentiality purposes, the names and identifying details of the client and family have been changed.

legal and social service delivery: a medical legal partnership (MLP) between CHOP and Penn Law's Interdisciplinary Child Advocacy Clinic. As part of the MLP, Mrs. Ago learned that she had enforceable legal remedies to address her son's special education needs and to prevent a utility shutoff which threatened to worsen his medical condition. The legal advocacy with the school resulted in Mrs. Ago attending a meeting to discuss her son's individualized education plan (IEP) and ensuring that he would receive appropriate services. Outreach to the utilities company resolved the crisis with the bill and provided additional subsidies to prevent the utility shutoff. Ultimately, the child welfare investigation was closed with no finding of maltreatment or neglect.

Mrs. Ago was stuck in a vicious cycle that is familiar for many poor and low-income parents struggling with unmet civil legal needs and enmeshed in a child welfare system ill equipped to respond to the collateral consequences of poverty. For decades, the child welfare system struggled to define child neglect and to meaningfully respond to the needs of vulnerable families known to the system. At the same time, health care professionals recognized the link between a child's home and community environment and their health outcomes, developing the concept of the social determinants of health (SDOH).[2] Doctors, nurses and hospital social workers wrestled with how to care best for children who were growing up in impoverished and under resourced communities, eventually reaching out to lawyers to provide representation addressing health harming legal issues such as housing, benefits and education services.[3] The resulting model of medical legal partnerships (MLP) has flourished in adult and pediatric settings over the past decades and provides a rich opportunity for expanding access to preventive legal services and evaluating the impact of legal advocacy on the health outcomes and stability of patients.

This article posits that pediatric medical-legal partnerships focused on preventive lawyering as a part of a collaboration between

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[2] Barry Zuckerman et al., *Medical-legal partnerships: transforming health care*, 372 LANCET 1615, 1615 (Nov. 8, 2008).

[3] Barry Zuckerman, Megan Sandel, Lauren Smith & Ellen Lawton, *Why Pediatricians Need Lawyers to Keep Children Healthy*, 114 PEDIATRICS 1, 224 (2004).

lawyers, social workers, health care providers including doctors, nurses, and psychologists, can play a vital role in decreasing the number of children involved in the child welfare system and transform pediatric care and child welfare practice. On an individual case level, MLPs can prevent a crisis triggering the involvement of the child welfare system by providing holistic legal supports as part of the clinical care team's intervention. On a systemic level, MLPs identify ongoing issues impacting the safety and well-being of children and families and provide opportunities for multidisciplinary collaboration to reform systems, laws, and policies.

Medical-legal partnerships in pediatric settings provide an opportunity for families to receive preventive legal services addressing the social determinants of health and the underlying roots of child neglect and maltreatment. While most medical-legal partnerships in pediatric and adult settings have focused exclusively on health outcomes, there is an opportunity to expand MLP's impact by deliberately and explicitly focusing on issues traditionally reserved for the child welfare system and studying the intervention's impact on involvement in the child welfare system. The potential impact of pediatric medical-legal partnerships on child welfare outcomes and entries is significant and deserves increased attention in both the practice and research literature.

Missing from the literature on medical-legal partnerships and their impact on the social determinants of health is the role of the child welfare system on families served by MLPs and the potential impact on family stability and decreased maltreatment as a result of the MLP's intervention. Most descriptions of legal partners refer to a "wide range of civil matters affecting health, including health insurance access and coverage, disability benefits, housing conditions, advance directives, and domestic violence,"[4] but neglect to mention child welfare systems or investigations as well. This may be due in part to an artificial separation between civil legal needs, such as housing and benefits, and the child welfare system.

The article begins by introducing the medical-legal partnership model in Part I and then defining neglect in the child welfare system

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[4] Edward Paul, et al., *Medical-Legal Partnerships: Addressing Competency Needs Through Lawyers*, 1 J. GRADUATE MED. EDUC. 304, 306 (2009).

in Part II. Part III examines the overlap between the social determinants of health and legal definitions of neglect and explores the role of lawyers in providing preventive legal services as an intervention to prevent entry into the child welfare system. Part IV considers the potential impact of pediatric MLP's to prevent child welfare system involvement in neglect cases and to provide tangible and individualized support to vulnerable children and families.

II. PEDIATRIC MEDICAL LEGAL PARTNERSHIPS

MLPs refer to models for creating formal collaborations between medical providers and legal service providers to address the social determinants of health. The first medical legal partnership was created in 1993, at Boston Medical Center's Department of Pediatrics, when Dr. Barry Zuckerman hired a legal services attorney to represent children and families with regards to housing and food instability issues that were directly impacting their health.[5] As Dr. Zuckerman noted, "[m]any child health conditions can be traced to social factors that are potentially remediable with an enforcement of existing laws and regulations."[6] Since then, medical-legal partnerships have expanded nationally with over 400 medical-legal partnerships identified in 2015 by the National Center for Medical-Legal Partnerships.[7] As evidence of their recent growth, the majority of medical-legal partnerships are less than five years old.[8]

Medical legal partnerships generally have broad goals aimed at transforming clinical care, improving health and well-being for

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[5] *See generally* MLPB, www.mlpboston.org (last visited Aug. 21, 2018).

[6] Zuckerman et al., *supra* note 3, at 224.

[7] Marsha Regenstein, Jessica Sharac & Jennifer Trott, THE STATE OF THE MEDICAL-LEGAL PARTNERSHIP FIELD: FINDINGS FROM THE 2015 NATIONAL CENTER ON MEDICAL-LEGAL PARTNERSHIP SURVEYS (Nat'l Ctr. for Medical-Legal P'ship, Aug. 2016), http://medical-legalpartnership.org/wp-content/uploads/2016/08/2015-MLP-Site-Survey-Report.pdf.

[8] *Id.* at 9 (detailing the MLP health care partners by organization type based survey responses).

individual patients and their families, and reforming policy and practice to address the social determinants of health. SDOH refers to the multitude of social and environmental factors that impact child health and well-being; including economic and housing stability, food insecurity, interpersonal violence, and mental health.[9] Indeed, the medical field, following in the work of public health professionals, recognized that the conditions of where someone is born, lives, and grows up have a profound and lasting effect on individual health.[10] The connection between the social determinants of health and health outcomes is well documented.[11]

At their core, medical-legal partnerships are defined by the formal collaboration between "at least one health care partner and one legal partner."[12] Medical providers can be hospitals, health systems including neighborhood based pediatric offices, and federally qualified health centers. [13] Legal partners include federally funded legal service corporation offices, legal aid offices providing civil legal services not receiving federal funding, and law school clinical programs and law firms. [14] Medical-legal partnerships generally include the on-site presence of an attorney in the health care setting, a collaborative approach to identifying priority issues in the selection of client population, and a

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[9] *See, e.g.,* Paul et al., *supra* note 4, at 304 (noting that "while the impact of social determinants of health is readily acknowledged by health care providers for vulnerable populations, addressing these needs remains a challenge"); Jennifer K. O'Toole et al., *Resident Confidence Addressing Social History: Is it Influenced by Availability of Social and Legal Resources?*. 51 CLINICAL PEDIATRICS 625, 625 (2012).

[10] Daniel Atkins et al., *Medical-Legal Partnership and Healthy Start: Integrating Civil Legal Aid Services into Public Health Advocacy*, 35 J. LEGAL MED. 195, 196-199 (2014) (discussing the origins of the SDOH and framework used by the public health community for SDOH).

[11] Helaine Barnett, LEGAL SERVICES CORPORATION, DOCUMENTING THE JUSTICE GAP IN AMERICA 9 (2005), http://www.lsc.gov/ press/documents/LSC%20Justice%20Gap_FIN AL_1001.pdf).

[12] Megan Sandel et al., *Medical-Legal Partnerships: Transforming Primary Care by Addressing the Legal Needs of Vulnerable Population*, 29 HEALTH AFF. 1697, 1699 (2010).

[13] Regenstein, *supra* note 7, at 9 (detailing the MLP health care partners by organization type based survey responses).

[14] *Id.* at 10.

commitment to increased communication with the goal of improved outcomes for clients and combined advocacy for policy reform.[15] The model is interdisciplinary by definition, incorporating the expertise of doctors, nurses, social workers, and lawyers to serve families. While the particular focus of the MLP may vary depending on the patient population, funding source, and expertise of the legal partner, the model presumes ongoing dialogue between the medical and legal partners about the needs of their patients, opportunities for cross training, and areas for combined advocacy efforts.

Currently, there are over 300 medical legal partnerships across the country, with 33 partnerships housed in children's hospitals or focused on pediatric populations.[16] The model originated in a pediatric setting with Dr. Barry Zuckerman at Boston Children's Hospital when he recognized that "addressing the social determinants of children's health is just as important as providing an immunization or a prescription."[17] While the basic tenets of the model remain the same across patient populations, there are additional issues raised by MLPs in the pediatric setting given that the practitioners are dealing with child and adolescent patients.

The MLP's determination of who is the "patient" to be referred to the legal partner and eventually become the "client" raises unique concerns and considerations. In most instances, the child's legal issue can only be addressed by working with the parent or custodian. For example, a child's asthma can be exacerbated by a landlord's failure to eradicate persistent roach infestations in the family's home. When the child is screened in the clinical pediatric setting for legal needs, the parent would reply affirmatively to the question of whether they have had problems with their landlord making repairs in the home. If the legal partner determines that there is a ripe legal issue to raise with the landlord, the attorney would be representing the parent-tenant and not the child-patient. The legal

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[15] Mallory Curran, *Preventive Law: Interdisciplinary Lessons from Medical-Legal Partnership*, 38 N.Y.U. REV. LAW & SOC. CHANGE 595, 596 (2014).

[16] Marsha Regenstein, Jennifer Trott, & Allana Willamson, STATE OF THE MEDICAL LEGAL PARTNERSHIP FIELD (2017), https://medical-legalpartnership.org/wp-content/uploads/2017/07/2016-MLP-Survey-Report.pdf.

[17] Zuckerman et al., *supra* note 3, at 227.

remedy for the housing problem is only accessible through the parent as the tenant, but inextricably linked to the child patient's health and well-being as a resident in the rental. At its core, pediatric MLPs recognize that children and adolescents are part of a family system and helping children means representing their parents on the range of legal issues that impact family stability, child health and well-being. As detailed later in the article, this reframing of services for children by providing legal support for their parents and caregivers could transform both pediatric care and child welfare practice.

In practice, pediatric MLPs offer an innovative example of working with families in a preventive fashion that explicitly includes legal services to parents. MFY Legal Services, Inc.'s MLP is an example of a pediatric MLP with its focus on children with serious behavioral health needs who are patients at Bellevue Hospital Center.[18] In 2014, the legal service provider partnered with the Department of Children and Adolescent Psychiatry to serve patients in their inpatient and outpatient clinics focusing their legal screening on special education and government benefits issues.[19] The clinical team of doctors, nurses, and hospital social workers identify potential legal issues with the patients, refer the families to the MLP attorney who is onsite at Bellevue two days a week, and then continue to work with the legal team to support the family throughout the case.[20] Highlighting a key difference between MLPs and a traditional referral based system for providing legal services, the hospital social worker assists the attorney even after a patient's discharge by "writing letters to request placement or other support services, providing access to psychiatric discharge summaries and other medical records that may be used as evidence in subsequent legal proceedings, and by coordinating wrap-around, out-patient services that help promote a child's stability in the community."[21] The combination of screening for legal needs within a particularly

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[18] Aleah Gathings, *MFY Legal Services, Inc.'s Medical Legal Partnership with Bellevue Hospital Center: Providing Legal Care to Children with Psychiatric Disabilities*, 18 CUNY L. REV. 1, 2 (2014).

[19] *Id.* at 16.

[20] *Id.*

[21] *Id.* at 17.

vulnerable population and structuring the relationship for continued collaboration is important when considering an MLPs impact on child welfare outcomes.

Another model, Health Law Partnership (HeLP), utilizes pediatric residents and law school students in the clinical setting through a partnership between Georgia State University's College of Law, Children's Hospital of Atlanta, and Atlanta Legal Aid Society (ALAS).[22] The students from the medical and law schools collaborate on cases to draft affidavits from medical experts to support claims for benefits, initiate legislative advocacy projects, and review medical records.[23] In one case where a client's family was confronting an infestation in their apartment, the law students researched the law and legal remedies while the public health students investigated the health risks from the infestation.[24] The landlord made the necessary repairs after the students' advocacy, and the MLP created a brochure to provide critical information on the law and the public health risks for future clients and the community.[25] The use of graduate students from different programs highlights the interdisciplinary nature of the MLP model, the role in training future advocates, and access to critical legal services for families in need.

A. Screening for Legal Needs in the Medical Setting

Focusing on preventive legal advocacy as opposed to legal services, primarily at the stage of court involvement, reframes the traditional delivery model of legal services. The screening tools are designed to identify legal issues that are in the nascent stage and

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[22] Robert Pettignano, Lisa Bliss & Sylvia Caley, *The Health Law Partnership: A Medical-Legal Partnership Strategically Designed to Provide a Coordinated Approach to Public Health Legal Services, Education, Advocacy, Evaluation, Research and Scholarship*, 35 J. LEGAL MED. 57 (2014) (quoting pages 68-71).

[23] *Id.* at 68-71.

[24] Pettignano et al., *supra* note 23, at 68-71.

[25] *Id.* at 69.

might not otherwise be considered by the patient or her family to rise to the level of benefitting from legal assistance.[26] This is a critical component of the MLP model since studies show that most low income and vulnerable individuals minimize not only the number of legal issues which they are facing, but also whether or not the problems are legal at all.[27] Recognizing that only one in five legal needs on average are addressed, [28] MLPs represent an innovative model for increasing resources and providing greater access to justice. The key element is the screening tool utilized by all MLPs to identify potential legal issues in their patient population.[29]

While mechanisms for identifying legal issues in the medical setting vary across MLPs,[30] most screening tools incorporate the I-HELP model pioneered by the National Center for Medical Legal Partnership. [31] I-HELP focuses on the primary legal issues impacting the social determinants of health and stands for "Income, Housing & Utilities, Education & Employment, Legal Status/Immigration and Personal Relationships/Family Stability."[32] Screening for legal issues in the clinical setting requires medical staff to have a basic understanding of the legal issues and to incorporate an additional layer of inquiry with the patient into their clinical practice. This raises issues of workflow, privacy concerns, data sharing, and staff training. Once the screening tool has been provided to the patient or administered by the clinical staff, the patient or patient's representative decides if they consent to be

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[26] Legal Services Corporation, *The Justice Gap: Measuring the Unmet Civil Legal Needs of Low-Income Americans*, 29 (June 2017).

[27] *Id.* (reporting that 86% of the legal problems reported by low income individuals nationally received insufficient legal help or no legal help at all).

[28] Barnett, *supra* note 11.

[29] Legal Services Corporation, *supra* note 26, at 31-34.

[30] Joanna Theiss & Marsha Regenstein, *Facing the Need: Screening Practices for the Social Determinants of Health*, 45 J. L., Med. & Ethics 431 (2017) (concluding that "screening is by no means consistent to operationalized in many MLPs.").

[31] *See* National Center for Medical Legal Partnerships, *How Legal Services Help Health Care Address the Social Determinants of Health,* https://medical-legalpartnership.org/wp-content/uploads/2014/02/How-Legal-Services-Help-Health-Care-Address-SDOH-August-2017.pdf (last visited Aug. 15, 2018).

[32] *Id.*

referred by the medical provider to the legal partner. In some MLPs, the legal partner may be on site in the clinical setting and the patient or their representative can speak immediately to an attorney or paralegal from the program. In instances where the legal partner is not regularly onsite in the medical setting, the medical partner must create a referral protocol to provide the legal partner with the referral, and consent to release information. The process, while superficially reflecting a traditional referral process, requires a greater degree of upfront planning, collaboration, and training so that the partners on both sides can communicate a unified message to the patient about the services, benefits, and constraints of the partnership.

The screening tool captures a number of legal risk factors which are linked to a child's health, safety, and well-being, including housing, education, and personal safety. While the specific wording and format of the screening tool varies, the language is non-judgmental and inclusive to ensure that families will honestly and fully disclose potential legal issues.[33] The questions are meant to identify the potential for a legal issue without significantly adding to the medical staff's workload or requiring them to move beyond their professional role or medical training. Examples of screening questions include the following:

> *Income and Benefits*: Are there times when you do not have enough food for your family? Have you been denied SSI benefits or disability benefits in the past three months?
>
> *Housing*: Are you concerned about being evicted? Do you have any issues with your gas, electric or water?

[33] The non-judgmental language and inclusiveness of the MLP screening tool can be contrasted with the risk assessment tools and questions traditionally used by child welfare which have been characterized as intimidating and off-putting leading families not to disclose potential risks or engage with services; *See, e.g.,* Vivek S. Sankaran & Marth L. Raimon, *Case Closed: Addressing Unmet Legal Needs & Stabilizing Families*, CENTER FOR THE STUDY OF SOCIAL POLICY, MICH. LAW, https://www.cssp.org/reform/child-welfare/Preventive-Legal-Representation.pdf.

> *Education*: Have you been denied any educational services in the past school year? Do you have any concerns about your child's safety in school?
>
> *Legal Status*: Do you have any concerns that you believe need the help of a lawyer? Do you need help accessing public benefits for you or your children?
>
> *Personal Safety*: Are you worried about your personal safety in your current relationship? Do you have questions or concerns about your child(ren)'s current custody or visitation arrangement?[34]

Another example of a screening from an MLP in a general pediatric practice focuses on identifying patient families with the three legal issues identified as most critical by the health care partner during the planning phase for the partnership. The brevity of the questions illustrates how broadly the screening tool can be worded to ensure that any nascent or pending legal issues are captured:

> In the last three months, have you been denied or lost social security, welfare, or food stamps?
>
> In the last three months, have you received mail that your gas, electric or water will be turned off?
>
> In the last three months, have you had problems with your landlord getting home repairs (mold, rodents, lead)?[35]

As a study of MLP screening practices nationally noted "[s]creening for the social determinants of health is a vital means to improve the health of populations by unlocking the social services and benefits that can be transformative in patients' lives."[36] The

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[34] *See* Penn Law Interdisciplinary Child Advocacy Clinic and Children's Hospital of Philadelphia, Medical-Legal Partnership Screening Tool.

[35] *See* Community Legal Services Screening Tool for MLP at CHOP Karabots MLP.

[36] Thiess & Regenstein, *supra* note 30, at 439.

screening process is triggered by an interaction with a medical provider, often part of the child's routine care, and not by a legal crisis as defined by the parent. As discussed later in the article, this process of screening for potential legal needs in a pediatric setting could also be transformative for child welfare practice in opening up a new set of resources and services for vulnerable families.

B. Growing Evidence of MLPs Impact

The evidence around MLP's efficacy is growing and encompasses a range of outcomes and measures of success in addressing the social determinants of health.[37] Recent studies of MLPs have evaluated their impact on health care costs, reduced emergency room visits, access to benefits, and cross-training of graduate medical students.[38] Studies show that legal issues range across the I-HELP categories, and patients who present with only one legal problem often, after assessment, have a number of legal issues identified.[39]

A 2007 survey of patients in the waiting room at Boston Medical Center's Pediatric Emergency Department unearthed "a cogent and troubling picture about how vulnerable families struggle to meet their basic needs, and therefore suffer hardships affording or accessing food, housing, healthcare, education services for their

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[37] *See generally* Johnna Murphy, Ellen Lawton, & Megan Sandel, *Legal Care as Part of Health Care: The Benefits of Medical-Legal Partnerships*, 62 PEDIATRIC CLINICS NORTH AMERICA 1263 (2015) (reviewing studies demonstrating the benefits of MLP in patients with asthma and sickle cell disease, increased compliance with health care, and reduction of stress).

[38] *See, e.g.,* Megan Sandel, et al., *Medical-Legal Partnerships: Transforming Primary Care By Addressing The Legal Needs Of Vulnerable Populations*, 29 HEALTH AFF. 1697.

[39] Robert Pettigano et al., *Can Access to a Medical-Legal Partnership Benefit Patients with Asthma who Live in an Urban Community?*, 24 J. HEALTH CARE POOR & UNDERSERVED 706, 715 (2013) (documenting financial benefits gained by MLP clients including public benefits, elimination of consumer debt, educational benefits, child support, health care coverage, housing and utilities benefits).

children, and safety."[40] In the survey, almost half of the families received a notice of a pending utility shutoff and 36% of the families reported skipping and reducing food intake because of an inability to afford sufficient food. Patient families, who did not seek out a legal services office or private attorney to address their concerns, reported great confusion over the legal nature of their issue.[41] Families who completed the survey noted that they had concerns about these legal issues for at least six months which highlights both the duration of these issues and the length of time during which an MLP could intervene. As the researchers discussed when critical legal issues remain unaddressed by families, "[t]his directly influences overall family stability and prevents families from providing the most basic needs to their children."[42]

While there are no studies specifically evaluating whether the MLP's intervention prevented entry into the child welfare system—and indeed some pediatric programs rule out patients as potential referrals to the MLP if there is an ongoing child welfare case—there are studies addressing the impact of the MLP on the patient's stress and well-being. One study of an MLP focusing on adult patients, the majority of whom had children, concluded that "MLP's may be a valuable intervention for reducing stress and improving well-being among vulnerable patient populations."[43] Another study looking at the impact of the MLP on children with sickle cell disease in Atlanta found that "access to legal care resulted in a positive impact on patients and parents."[44]

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[40] Megan Sandel et al., *The MLP Vital Sign: Assessing and Managing Legal Needs in the Healthcare Setting*, 35 J. L. MED. 41, 48 (2014).

[41] *Id.* at 49-50 (finding that 15% of the families who completed the second half of the survey had sought assistance with half of that number seeking free legal services and only one of the six families that sought legal services was able to access them).

[42] *Id.* at 50.

[43] Anne M. Ryan, Randa M. Kutob, Emily Suther, Mark Hansen & Megan Sandel, *Pilot Study of Impact of Medical-Legal Partnership Services on Patients' Perceived Stress and Wellbeing*, 23 J. HEALTH CARE FOR THE POOR AND UNDERSERVED 1536 (2012).

[44] Robert Pettigano, Susan Caley, & Lisa Bliss, *Medical-Legal Partnership: Impact on Patients with Sickle Cell Disease*, 128 PEDIATRICS 1482 (2011).

In 2011, Project MUSE focused on the issue of energy instability through the PhilaKids medical-legal partnership with St. Christopher's Hospital for Children and Legal Clinic for the Disabled. The goal was to standardize both screening for utilities issues and the medical certification process across doctors. The medical certification can prevent a utility shutoff if the doctor certifies that a cessation of electricity, gas or water would impair a child's medical condition.[45] The results demonstrated that simply by screening all patients for energy instability and standardizing the medical criteria for approving a certification, the number of families who take advantage of the legal remedy to combat a shut off significantly increased.[46] The evidence, even in its early stages, demonstrates that including legal services as part of a pediatric practice with low-income and vulnerable families is beneficial.

III. NEGLECT AND CHILD WELFARE

By recognizing the role that unmet legal needs play in family and child well-being, the child welfare system can begin to reframe cases of neglect. The MLP model offers preventive legal services for children by providing legal representation to their parents before issues have reached a crisis point or become court involved. In order to do that, it is important to understand the current framing of neglect under the law, the relationship between neglect and the social determinants of health, and the adverse consequences of removal and foster care on child health and well-being.

While specific terms vary from state to state, the common elements of the legal definition of neglect are a failure on the part of the parent or person legally responsible for the child in providing food, shelter, care, or supervision with a resulting harm to the

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[45] Daniel R. Taylor et al., *Keeping the Heat on for Children's Health: A Successful Medical-Legal Partnership Initiative to Prevent Utility Shutoffs in Vulnerable Children,* 26 J. HEALTH CARE FOR POOR & UNDERSERVED 676, 678 (2015).

[46] *Id.* at 682-83.

child.[47] Florida codifies neglect as "when a child is deprived of, or is allowed to be deprived of, necessary food, clothing, shelter, or medical treatment."[48] Massachusetts defines neglect as "failure by a caregiver, 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."[49] Montana specifies that physical neglect includes "failure to provide cleanliness and general supervision" in addition to "failure to provide basic necessities, including but not limited to appropriate and adequate nutrition, protective shelter from the elements and appropriate clothing related to weather conditions."[50]

Some states distinguish among the type of neglect, separately defining medical neglect and educational neglect. Arkansas specifies that neglect includes "failure to provide a shelter that does not pose a risk to the health or safety of a child."[51] Minnesota defines neglect to include "failure to ensure that the child is educated" as required by State law.[52] Oklahoma includes the failure to provide "medical, dental or behavioral health care" as part of its definition of neglect.[53] A handful of states carve out exceptions to their neglect statutes clarifying that poverty or lack of access to food, shelter, and medical care are not a sufficient basis for child neglect. For example, in New Hampshire, the neglect statute notes that the "deprivation is not due primarily to the lack of financial means of the parents, guardian or custodian."[54] In that instance, a family with inadequate housing should not be considered neglectful, solely on the basis of a lack of housing, but rather in need of concrete supports and services to improve their housing. Additionally, a parent unable

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[47] *See generally* 23 PA CONS. STAT. § 6303 (2018) (defining serious physical neglect as "the failure to provide a child with the adequate essentials of life including food, shelter or medical care.").

[48] FLA. STAT. ANN. § 39.01 (2018).

[49] 110 MASS. CODE REGS. 2.00 (2018).

[50] MONT. CODE ANN. § 41-3-102 (2018).

[51] ARK. CODE ANN. §12-18-103 (2018).

[52] MINN. STAT. ANN. § 626.556.2 (2018).

[53] OKLA. STAT. tit. 10A, § 1-1-105 (2018).

[54] N.H. REV. STAT. ANN. § 169-C:3 (2018).

to afford sufficient food for their family is not neglecting their child under the law, unless the parent affirmatively refused programs or services that would enable them to obtain sufficient food.

In the legal definition of neglect, the focus is on a child's basic needs including food, housing, education, and access to medical care. For children growing up in poverty and under resourced communities, many of these basic needs are severely constrained, yet are maintained in the law as the basis of neglect when not provided by parents. The child welfare system historically has not included an assessment of the family's material needs and the system or court's ability to provide concrete services for families.[55] The focus instead is on personal responsibility and parental action or inaction as the foundation of neglect, ignoring the role of deep intergenerational poverty.[56] Nevertheless, a recent study found that income inequality is a risk factor associated with child maltreatment with researchers finding that "higher rates of income inequality across US counties are significantly associated with higher county level rates of child maltreatment."[57] As child welfare researchers noted, the connection between poverty and neglect is complex with poverty increasing the risk of neglect precisely because access to basic needs is so deeply constrained.[58] One study assessed the link between repeated involvement in the child welfare system and deep-seated poverty issues concluding that "contextual factors like poverty are essential to understanding a family's needs when addressing child maltreatment" and families "may need services that attend to their poverty and most basic needs before, or

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[55] *See generally* Theo Liebman, *What's Missing from Foster Care Reform? The Need for Comprehensive, Realistic, and Compassionate Removal Standards,* 28 HAMLINE J. PUB. L. POL'Y. 141, 149-162 (2006).

[56] *Id.*

[57] John Eckenrode, Elliott G. Smith, Margaret McCarthy & Michael Dineen, *Income Inequality and Child Maltreatment in the United States*, 133 PEDIATRICS 454, 457 (2014), http://pediatrics.aappublications.org/content/pediatrics/133/3/454.full.pdf.

[58] *Id.* at 457-58.

simultaneously with, attending to their higher order needs of caring attentively for their children."[59]

The vast majority of families reported to child welfare agencies and with cases in Family Court nationally involve allegations of neglect. Of the 273,539 children entering foster care in fiscal year 2016, 61% were removed because of neglect and 10% as a result of housing.[60] In contrast, the number of cases involving either physical or sexual abuse constituted only 16% of the cases.[61]

Understanding the number of children in foster care as a result of neglect allegations is important when examining the role that preventive legal services, such as medical legal partnerships, can have in reducing the number of children removed from their parent's care. The scope of the problem is vast, and the impact of removal has enormous consequences on children and families. Studies have shown that removal of a child from their home, for even the relatively short period of time of 30 days or less, harms a child.[62] In another study, children removed from their home due to neglect were found to have spent more time in out of home placements and ultimately were less likely to be reunified with their parents.[63] Legal

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[59] J.H. Escavarage, *Child Maltreatment Entrenched by Poverty: How Financial Need is Linked to Poorer Outcomes in Family Preservation*, 93 CHILD WELFARE 79, 92-93 (2014).

[60] Child. Bureau, *The AFCARS Report No. 24: Preliminary FY 2016 Estimates as of October 20, 2017*, U.S. DEP'T HEALTH & HUM. SERV. (Nov. 30, 2017), https://www.acf.hhs.gov/sites/default/files/cb/afcarsreport24.pdf (noting that the other reasons for removal not included in the 61% removed because of neglect were physical abuse, parent incarceration, parental alcohol or drug abuse, child behavioral problem and caretaker inability to cope).

[61] *Id.*

[62] Vivek Sankaran & Christopher Church, *Easy Come, Easy Go: The Plight of Children Who Spend Less than Thirty Days in Foster Care*, 19 UNIV. PA. J. L. SOC. CHG. 207, 211-213 (2016). *See also* Joseph J. Doyle, Jr., *Child Protection and Child Outcomes: Measuring the Effects of Foster Care*, 97 AM. ECON. REV. 1143, 1149 (2007) (finding that children who remained in the home had better long-term outcomes than children who were removed from their parent's care into foster care).

[63] Kimberly Bundy-Fazioli, Marc Winokur, & Tobi DeLong-Hamilton, *Placement Outcomes for Children Removed for Neglect*, 88 CHILD WELFARE 85, 97 (2009) (finding a "statistically significant association between removal reason and reunification" and children removed for neglect were younger at the

scholars have long called for an overhaul of the legal standards for removing children from their parents' care arguing that current laws across the country fail to account for the problems faced by children once they are in the foster care system and the inherent harm to the child from removal itself.[64] Indeed, when a child is removed from their parent's care—for any amount of time—all aspects of their life and care are impacted. They may not be able to attend the same school or maintain contact with their relatives or siblings. Their healthcare may be interrupted as they are no longer able to be seen by the same pediatrician.[65] For a child with moderate to severe medical needs, the disruption in custody can mean a disruption in their medical care. The collateral consequences of a removal are significant, and as a result should be avoided whenever possible.

IV. ACCESS TO LEGAL SERVICES FOR FAMILIES IN THE CHILD WELFARE SYSTEM

Representing parents and children in foster care routinely unearths a timeline of missed opportunities for families confronting the burden and stress of multiple legal issues which spiral out of control before coming to the attention of the child welfare system. The initial interview with a client, and subsequent investigation of their case, provides insight into how the family came to live in substandard housing, not have enough food to eat, or lack access to necessary education supports. Attorneys for parents and children in family court can identify points in time where an intervention of legal services or social supports may have prevented the crisis or situation which brought the family into the child welfare system. A family renting an apartment infested with roaches, which exacerbate a child's asthma, did not realize their rights as tenants to withhold rent or to demand repairs from their landlord. A Spanish-speaking

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time of entry into the child welfare system and less likely to reunify with their parents than children removed because of abuse).

[64] *See, e.g.*, Theo Liebman, *What's Missing from Foster Care Reform? The Need for Comprehensive, Realistic, and Compassionate Removal Standards,* 28 HAMLINE J. PUB. L. POL'Y. 141, 148 (2006).

[65] Megan Sandel et al., *supra* note 40, at 43-44.

mother, who was not able to understand the utility notices written in English about a potential shutoff of electricity, did not know her options for payment plans, assistance programs, or medical certifications to halt the shutoff. Another family of four struggled to feed their children after food stamps were improperly denied. In each case, the resulting crises could reasonably lead to a child welfare investigation and ultimately a case of neglect for the parent's failure to meet the child's basic needs. The only difference between the narratives is the timing and the ability to access legal services to address the issues.

In the current system, a family brought to the attention of the child welfare system does not receive a lawyer until their child has been removed from their care or a case has been brought in family court. For the thousands of families in the child welfare system who are at or below the poverty line, the reality is that they will not have access to legal advocacy and support, unless the worst-case scenario happens, and their child is removed from their care.

This lack of access to legal advocacy, absent a crisis situation, is reflected in the access to justice problems for low-income individuals with legal needs where the right to counsel is not guaranteed. Studies show that low-income individuals have an average of two unmet legal needs.[66] These unmet legal needs are often tied to the conditions giving rise to neglect and maltreatment yet continue to go unnoticed unless it reaches the crisis point. As one commentator noted, "[r]isk factors for child maltreatment are present in many areas where legal remedies may exist but are difficult for low income parents to access."[67] In analogous terms, even though there may be a treatment or remedy for the parents' issues, they can't get any assistance until the situation is serious enough to go to the emergency room. There is no process built in

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[66] Elizabeth Tobin Tyler, *Medical-Legal Partnership in Primary Care: Moving Upstream in the Clinic*, AM. J. LIFESTYLE MED., 2017, at 2, http://journals.sagepub.com/doi/10.1177/1559827617698417.

[67] Sarah H. Ramsey, *Child Well Being: A Beneficial Advocacy Framework for Improving Child Welfare*, 41 U. Mich. J.L. Reform 9, 22-24 (2007) (describing the role of medical legal partnerships in creating a more "expansive concept of child well-being" and concluding that "[a]dding lawyers to the pediatric treatment team puts child advocates in an important position to further children's interests.").

for low-income parents and families to get legal help *before* the issue is exacerbated and to prevent the crisis.

V. SHIFTING TOWARDS PREVENTIVE LEGAL SERVICES FOR FAMILIES

The concept of prevention is well established in the medical field, but still a relatively new concept in the legal field, particularly with regards to preventive legal services in child welfare cases.[68] Ellen Lawton and Megan Sandel, national experts in the MLP field, highlighted the connection between a preventive lawyering practice in civil legal services and the health care setting; "[t]o provide early, preventive legal aid services, attorneys must practice civil law where clients frequently visit and where the ides of prevention already carries weight: healthcare sites. Indeed, legal aid services can only be accessed preventively in a setting where clients are seen routinely and can be screened for legal problems."[69] This concept applies equally well in the child welfare context, utilizing pediatric medical providers to partner with legal services to identify areas of need and to provide a range of interventions including legal advocacy and social service supports. The pediatric care setting provides a trusting setting for routine, meaningful and individualized interactions that can identify potential risks to family stability and child well-being.

In pediatric medicine, there has been a shift towards recognizing the critical role that parents play in child development and well-being. Dr. Barry Zuckerman, the founder of the first medical legal partnership, advocates for two-generation pediatric care.[70] Dr. Zuckerman reflects that "the best way to help children is to help their parents, and the best way to reach parents is through

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[68] Ellen M. Lawton & Megan Sandel, *Investing in Legal Prevention: Connecting Access to Civil Justice and Healthcare Through Medical-Legal Partnership*, 35 J. LEGAL MED. 29, 37 (2014).

[69] *Id.* at 38 (internal citations omitted).

[70] Barry Zuckerman, *Two Generation Pediatric Care: A Modest Proposal*, 137 PEDIATRICS 1, 1 (2016).

their children." The vision of two-generation pediatric care is reminiscent of the model for holistic representation, particularly within family defense.[71] The vision of care emphasizes that "to develop new interventions, we also need to know about the family's home, neighborhood, and community (faith, friendship, and support systems)."[72]

Attorneys for parents and children in the child welfare system have long utilized an interdisciplinary approach to advocate for their clients, incorporating social work expertise to assess and to identify individualized and appropriate resources to support a family. As parents' attorneys know from representing parents attempting to regain custody of their children, considering the entire family unit and the best interests of the child is essential in successfully representing the family. One example of this concept of preventive legal services, unmet legal needs, and the child welfare system is the Detroit Center for Family Advocacy (CFA). CFA focuses on providing legal services during the child welfare investigation phase, recognizing that many families enmeshed in the child welfare system have unresolved legal needs that will be better met by a legal team than by the child welfare system.[73] Indeed, the initial evaluation of the program concluded that "providing families with a multidisciplinary team can help keep children safe with their families by resolving those legal issues that are destabilizing the family unit."[74] While the program is not a formal MLP, it shares the common characteristics of screening for unmet legal needs, responding with an interdisciplinary approach, and working with the entire family unit to ensure the child's safety and well-being.

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[71] *See generally* Kara Finck, *Applying the Principles of Rebellious Lawyering to Envision Family Defense*, 23 CLINICAL L. REV. 83 (2016).

[72] Zuckerman, *supra* note 70, at 2.

[73] Vivek S. Sankaran & Marth L. Raimon, *Case Closed: Addressing Unmet Legal Needs & Stabilizing Families*, CENTER FOR THE STUDY OF SOCIAL POLICY, https://www.cssp.org/reform/child-welfare/Preventive-Legal-Representation.pdf (last visited Aug. 21, 2018).

[74] *Id.* at 5.

VI. MLP AND THE POTENTIAL IMPACT ON CHILD WELFARE PRACTICE

By delivering preventive legal services to address the social determinants of health, MLPs can improve family well-being and prevent involvement in the child welfare system on the sole basis of neglect. The connection between preventive legal services and child welfare prevention is obvious. As one MLP attorney reflected, "[h]aving legal and medical services in the same place helps poor and overburdened families save time and money, leaving them with more resources to focus on their children."[75] Traditional medical-legal partnership issues, identified in the literature as barriers to good health, are also indicative of an increased risk of involvement in the child welfare system. For example, a mother's failed negotiation with her landlord in a dispute over a rental unit can quickly become a crisis resulting in a petition alleging neglect for the parent's failure to provide adequate and appropriate housing. Losing their job and being denied access to unemployment benefits, a parent may fall behind on their utility payments during the winter and, as a result, could place an asthmatic child at risk when the heat is shut off. A failure to provide specialized education services and health care can lead to an increase in the number of absences from school culminating in an educational neglect case filed in court. Lack of access to individualized and meaningful behavioral health services for both the parent and the child can negatively impact a family's stability. Indeed, oftentimes seeking assistance for a child with serious behavioral issues can result in a child welfare investigation framed in a negative light, as the parents' inability to control the child or as the only means available to access behavioral health services for the child and family.

Neglect cases are ripe for rethinking the role of early intervention and preventive legal services. A child welfare practitioner training manual directs that a caseworker should assess

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[75] Lisa Pilnik, *Practicing Preventative Law: A Day in the Life of a Medical-Legal Partnership Attorney*, 27 CHILD L. PRAC. 1, 14 (2008).

for neglect if the child "begs or steals food or money; lacks needed medical care or dental care, immunizations or glasses; lack sufficient clothing for the weather" or when a parent "indicates that lack of necessary supports is impacting the ability to meet the child's needs [or] feels overwhelmed addressing a range of challenges."[76] A preventative lawyering approach based on the medical-legal partnership model could directly impact the likelihood of a child entering foster care by addressing the legal issues and family needs before the moment of crisis and implementing legal remedies sooner. In the scenario envisioned by the training manual, a family would be screened for food instability and housing issues by their treating pediatrician, a trusted professional who has an ongoing and regular relationship with the family. The family would honestly disclose the issues in obtaining sufficient food and safe housing. Deliberately removed from the child welfare investigation process, the parent could share that they were overwhelmed by the issues and be provided with an immediate and onsite referral to legal assistance. The intervention is based in the trusting relationship with the medical provider, focused holistically on the entire family, and based in the notion that the issues and challenges have legal remedies.

Indeed, the tools of the child welfare system, as currently constructed, are not sufficient to meet the concrete and material needs of low-income families where poverty is at the root of the neglect case.[77] As a policy brief advocating for increased preventive and concrete services noted "[p]utting families on a path to economic stability and success, instead of only providing emergency finance assistance is usually considered well beyond child welfare's scope and typically agencies have limited resources and capacity to respond to ongoing economic need."[78] Indeed, a

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[76] Child Welfare Information Gateway, *Acts of Omission: An Overview of Child Neglect*, BULLETIN FOR PROFESSIONALS (July 2018), https://www.childwelfare.gov/pubs/focus/acts.

[77] Megan Martin & Alexandria Citrin, *Prevent, Protect, & Provide: How Child Welfare Can Better Support Low-Income Families*, CENTER FOR THE STUDY OF SOCIAL POLICY 1, 3 (2014), https://www.cssp.org/policy/2014/Prevent-Protect-Provide.pdf.

[78] *Id.*

child welfare investigation for a family facing multiple challenges, as a result of their poverty, can dramatically increase parental stress and further destabilize a family by adding additional responsibilities such as parenting classes and therapy without corresponding resources. A referral from a child welfare caseworker for therapy or parenting classes is not going to address the family's need for access to child care and food stamps.[79]

Research confirms that poverty status and economic stress are linked to child welfare involvement, [80] and recent studies documented specifically that home foreclosure [81] and unemployment[82] are linked to child maltreatment. The stress of a family living in poverty with limited access to resources, benefits, or improved housing increases the risk of involvement in the child welfare system either through improper assessment at the investigation stage or overinclusion at the removal stage.[83]

When considering the role of preventive law in reducing neglect cases, home foreclosure and evictions are helpful examples since the legal issues happen over a lengthy period allowing for multiple points for potential intervention by the MLP.[84] There are also discrete legal remedies in many cases involving the loss of a family's home, and the child welfare system is not equipped to deal with the concrete needs and legal services required when a family is facing a housing crisis.[85] Traditionally, the child welfare system's response to a family with a housing crisis is to refer to a homeless shelter, local legal services agency, or smaller emergency financial assistance.[86] A referral to a lawyer is not a part of their toolkit and, as a result, potential legal remedies for the family remain unmet.[87] A study of home foreclosure filings in Wisconsin found a significant

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[79] Martin & Citrin, *supra* note 77, at 3.

[80] Lawrence M. Berger, PhD et al., *Home Foreclosure and Child Protective Services Involvement* 136 PEDIATRICS 299, 300 (2015).

[81] *Id.*

[82] *Id.*

[83] *Id.* at 299.

[84] *Id.* at 300.

[85] Martin & Citrin, *supra* note 77, at 3.

[86] *Id.*

[87] *Id.*

link between home foreclosures and involvement in the child welfare system.[88] Families that "experience a foreclosure filing in the next 6 to 12 months are at 70% greater risk of a CPS investigation than households that will not subsequently experience a foreclosure. Indeed, the entire period from 12 months before to 6 months after the filing is associated with elevated risk of CPS investigation."[89] This is another example where an intervention of legal services triggered by the involvement of the MLP could change the trajectory of those CPS investigations during the crisis period.

As one of the few MLPs designed to impact child-maltreatment rates for infants and to address child welfare involvement with their patients, Project DULCE represents another example of a pediatric MLP intervention that could have a significant impact on child welfare outcomes and practice.[90] Standing for "Developmental Understanding & Legal Collaboration for Everyone," Project DULCE was piloted in the Boston Medical Center's Department of Pediatrics and presents a unique model incorporating family specialists into the MLP to address specific issues of child maltreatment and well-being. The model is a combination of a traditional MLP and the Healthy Steps Program, introducing a child development specialist into the pediatric care team.[91] The focus is on working with infants and their families during the first six months, given the high-risk period for child maltreatment and frequent interactions with the infant's pediatrician.[92]

Project DULCE included the local child welfare agency, Department of Children and Families, as a partner on the project's Advisory Board, and the Family Specialists were trained to ask "challenging questions about depression, substance abuse, [and]

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[88] Berger et al., *supra* note 80, at 305-306.

[89] *Id.*

[90] Robert Sege & Grace Morakinyo, Project Dulce, Final Report September 2010-December 2013, available at https://www.cssp.org/reform/early-childhood/qic-ec/Final-Report-Project-Dulce-Boston-MA.pdf (last visited August 15, 2018).

[91] *Id.*

[92] Robert Sege et al., *Medical-Legal Strategies to Improve Infant Health Care: A Randomized Trial*, 136 PEDIATRICS 2 (2015).

intimate partner violence."[93] During the period for the evaluation, Project DULCE included families with DCF involvement, although there were no conclusions made by the evaluators as to the project's impact on maltreatment levels.[94] Given the unique model of the MLP, incorporating family specialists into the MLP team and focusing on families over six months after the birth of a child, it would be particularly helpful to understand its potential impact on the level of maltreatment and involvement of DCF.

Fundamentally, the program aims to "support[] the building of protective factors at the individual and relationship (family) domains of the social ecology."[95] Similar to the results from other surveys of the patient population, the families surveyed through the Project DULCE reported problems with food insecurity, housing stability, and payment of utility bills.[96] The initial evaluation revealed that families in the program received greater concrete supports including food, utilities, and housing.[97] This correlated with the project's understanding that "research suggests that the early provision of concrete support[s] may protect against child neglect and abuse and reduce parental stress."[98]

VII. INCORPORATING MLPS INTO CHILD WELFARE

The notion of overhauling the child welfare system nationally to provide comprehensive legal services for families is likely unrealistic in the current fiscal and political climate. However, existing pediatric MLPs can expand their focus to incorporate child welfare issues and partners, and thereby move upstream to prevent neglect proceedings in court.[99] Legal partners can expand their screening to include questions on involvement and prior history with the child welfare system in addition to the traditional questions

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[93] Sege & Morakinyo, *supra* note 90, at 42.
[94] *Id.* at 3.
[95] *Id.*
[96] Sege et al., *supra* note 92, at 5-6.
[97] Sege & Morakinyo, *supra* note 90, at 3.
[98] Sege et al., *supra* note 92, at 7.
[99] *Id.* at 2.

identifying civil legal needs. MLP trainings for clinical partners can focus on child welfare issues, including a greater understanding of the investigation process, basis for neglect, and preventive services available to families. As opposed to focusing solely on traditional civil legal needs, MLPs in pediatric settings should embrace working with families undergoing child welfare investigations and partner with family defenders representing parents with neglect cases in Family Court to provide legal support at the investigation stage, as well as during a court proceeding. States, counties, and local child welfare agencies can partner with MLPs to evaluate the role of preventive legal services in reducing neglect cases and improving well-being for poor children and families. Researching the unmet civil legal needs in families investigated by child welfare would help MLPs respond to the greatest need and track the efficacy of the intervention.

Further studies are needed to understand both the range of legal needs that families face when they come into contact with the child welfare system and the extent of overlap between civil legal needs and involvement in the child welfare system due to allegations of neglect. This research could help refocus preventive services towards enforcing legal rights and remedies available to families who would otherwise be alleged neglectful. A focus on the unmet civil legal needs of families might decrease not only the number of neglect cases but also the number of children placed in foster care unnecessarily. In light of the adverse consequences of even a brief stay in foster care,[100] and the preliminary data on the success of MLPs intervention, expanding MLPs to include child welfare practice is worthy of greater discussion, innovation, and evaluation.

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[100] *See generally* Sankaran & Church, *supra* note 62, at 211-13.