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Chapter 22

PREVENTING CHILD MALTREATMENT THROUGH MEDICAL-LEGAL PARTNERSHIP

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ABSTRACT

There has been significant attention in recent years to health care delivery models that address social determinants of health. One such model is medical-legal partnership (MLP). MLPs join health care providers with lawyers to address health-harming legal needs in the lives of vulnerable patients. Research on MLPs has demonstrated their success in reducing stress and increasing health and well-being in the patients they serve and in their families. This chapter explores the possibility of using MLP as a tool to prevent child maltreatment.

INTRODUCTION

There has been significant attention in recent years to health care delivery models that address social determinants of health. One such model is medical-legal partnership (MLP). MLPs join health care providers with lawyers to address health-harming legal needs in the lives of vulnerable patients. Research on MLPs has demonstrated their success in reducing stress and increasing health and well-being in the patients they serve and in their families. This chapter explores the possibility of using MLP as a tool to prevent child maltreatment.

Data support the proposition that parental stress as well as conditions of poverty contribute to child maltreatment (1, 2). To the extent that MLPs reduce stress on families and alleviate conditions of poverty by addressing issues such as substandard housing and strained household resources, they may help prevent child maltreatment as well. MLPs will encounter ethical challenges if they strive to address child maltreatment through direct representation of parents or children, however. Given the competing professional obligations around mandatory

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reporting of abuse and neglect, direct representation of families involved in the child welfare system has the potential to disrupt the collaboration between healthcare providers and lawyers, which is the hallmark of medical-legal partnership. MLPs are thus better suited to “work upstream” and address conditions that lead to child maltreatment.

CAUSES OF CHILD MALTREATMENT

When this chapter refers to “child maltreatment” it includes both child abuse and child neglect. Child abuse is commonly defined as “the non-accidental commission of any act by a caregiver on a child (in most states defined as a person under age 18 years) that causes or creates a substantial risk of physical or emotional injury; constitutes a sexual offense, or any sexual contact between a caregiver and a child under the care of that individual” (3). Child neglect has been defined as “the 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; provided, however, that such inability is not due solely to inadequate economic resources or solely to the existence of handicapping conditions” (3).

Much has been written about causes of child maltreatment (1, 4, 5). In particular, scholars have connected neighborhood poverty and family economic insecurity with child maltreatment (1, 4, 6). There is also evidence that child maltreatment is related to stress. One researcher has written, “[I]ack of income may influence parental emotional well-being and parenting practices through increased stress. Parents that are highly stressed are more likely to engage in rapid information processing as a way to control their children’s behaviors” (1, 7). This means that parents form immediate, negative reactions to their children’s behaviors, and that parental stress contributes both to the formation of those negative assessments of behavior and to the resulting abuse (8).

Lack of income may also lead to behaviors better characterized as neglect, as parents may not have the resources to provide for their children (6). For example, parents living in poverty may not be able to afford childcare and may leave their children unattended when they go to work. Parents living in poverty may struggle to provide safe housing for their children. Even affluent parents may struggle to manage their children on a day-to-day basis (9). Under the best of circumstances, children cry, resist toilet training, defy their parents, and create chaos in a family unit – all factors contributing to abuse (10). Children with disabilities also increase parental stress (9). Children who have a hard time achieving developmentally appropriate cognitive, emotional, and physical milestones, children who have conditions that include heightened fussiness or distractibility, and children who require high levels of care, put enormous strain on parents, which can affect the parent-child relationship and lead to higher rates of abuse (9). When you add poverty to the mix, the stress may cause some parents to lose their tempers more quickly and discipline their children inappropriately. One model for understanding this dynamic is the Family Stress Model, which puts forth the idea, based on decades of research around the globe, that economic hardship leads to economic pressure, which causes emotional distress that puts strain on family relationships and the ability of parents to respond appropriately to their children (7).

Scholars who have examined the relationship between poverty and child maltreatment have concluded “the available evidence indicated that few personal differences had been found to distinguish abusing and neglecting parents from other impoverished parents other than depression, low self-esteem, and feelings of helplessness . . . these factors undermine one’s ability to cope with poverty and its stressors, which include its various material hardships” (4). The stress of poverty has also been shown to contribute to unhealthy coping methods, such as drug and alcohol abuse, which likewise compromise parental judgment (4). Strategies to reduce child maltreatment therefore must address parental stress, which includes conditions of poverty and child health (4).

Given the prominent role that parental stress plays in child maltreatment, and given that child maltreatment contributes to negative health outcomes for children that persist throughout their lives, the medical-legal partnership model of intervention may be a uniquely well-suited tool of child maltreatment prevention.

HISTORY AND PURPOSE OF MLPs: SOCIAL DETERMINANTS OF HEALTH AND ADVERSE CHILDHOOD EXPERIENCES

It is well-established that crucial components of health and well-being reside in social factors that lie outside the traditional purview of health care (3, 11-14). These factors are commonly referred to as “social determinants of health” (12). The social determinants of health – where people live, work, and play – contribute to overall health as much if not more than the quality of health care services (3). Social determinants of health consist of access to green spaces and clean air, access to nutritious food and safe housing, access to quality education, and so on. Whereas Americans used to have a narrow understanding of factors that contribute to overall health – focusing almost entirely on access to medical care for individuals – we now understand that personal health is intrinsically linked to living and working conditions in homes and communities, and the broader economic and social opportunities and resources available (3).

Another advance in our understanding of the factors that contribute to overall health is the role of adverse childhood experiences, or ACEs, in health and well-being (3, 15, 16). ACEs include emotional abuse, physical abuse, sexual abuse, domestic violence, household substance abuse, mental illness in the household, parental separation or divorce, and incarcerated household members (16). Researchers who study the consequences of adverse childhood experiences have noted that “childhood stressors such as abuse, witnessing domestic violence, and other forms of household dysfunction are highly interrelated and have a graded relationship to numerous health and social problems” (16).

Because long-term health relies so heavily on improving social determinants of health and on reducing the number of ACEs, health care delivery models must address both. It is in this context that American health care providers have devoted increased attention to social factors, as the health care system acknowledges the constraints on its ability to improve population health through individual access to traditional medical care alone (14).

One innovative way in which health care systems have begun to address social determinants of health is through medical-legal partnerships (11, 12). Many health-harming social conditions have legal remedies. For example, a family without adequate access to food may have been wrongfully denied governmental food assistance. A family whose child with a

disability is struggling in school may be entitled to an individualized education program under federal special education law. A family living in substandard housing where conditions are present that exacerbate health conditions may have protections in local housing codes. A child who has been prescribed a medical treatment or equipment but the child's Medicaid health plan refuses to cover it, may have protections in the Social Security Act. And a family experiencing intimate partner violence may benefit from a personal protection order. MLP lawyers use their legal expertise to help families gain access to these health-improving legal remedies.

The idea for MLP arose when Dr Barry Zuckerman, working with vulnerable families in the Boston Medical Center in 1993, kept encountering children who were failing to thrive (17, 18). Dr. Zuckerman hired a lawyer to help advocate for these patient families, particularly with regard to accessing public benefits and safe housing (17). Support for this model grew over the years and was endorsed by the American Bar Association in 2007, the American Academy of Pediatrics in 2007, and the American Medical Association in 2010. To date, there are over 300 MLPs in 48 states (19). They are housed in different types of health care institutions – from stand-alone health clinics to vast University hospitals; from legal aid offices to law school clinics (19). The MLP model allows health care providers and lawyers to work together to address social determinants of health for vulnerable patients (12). MLPs integrate lawyers into the health care team so that lawyers may address health-harming legal needs for patients (12).

How MLPs Work

Legal training for medical providers forms the foundation of an MLP. MLP lawyers work with medical providers to help them identify health-harming legal needs of their patients including, for example, issues with public benefits, special education law, domestic violence, and housing law. Lawyers may give providers some basic tools so that providers are able to engage in limited advocacy on behalf of their patients even before calling in the legal team. For example, a doctor trained in special education law may provide their patient with a letter requesting a special education evaluation from a school. Providers who have been trained in medical emergency exceptions to utility shut-offs may provide their patients with an advocacy letter that the patient can present to a utility company. And providers who have been trained in housing law may send a letter to a landlord asking the landlord to repair health-harming conditions such as cleaning mold or exterminating rodents. In these scenarios, lawyers equip providers with letter templates or with sample language to include in the provider's own advocacy letter so that health care providers may take the initiative to address social determinants of health for their patients.

If provider advocacy does not solve the problem, or if a problem is legally complex and requires attorney intervention from the outset, providers refer the patient to the MLP lawyer. Lawyers in MLPs typically provide direct legal representation to low-income clients on civil legal issues that affect health. As noted above, these might include any combination of housing matters, public benefits, family law, domestic violence, education law, and even immigration law or employment law (13). Researchers who have studied MLPs have observed that “medical-legal partnerships can become an essential component of the patient-centered medical home by making timely, on-site legal interventions available to patients and families” (11). There are many laws that exist to protect the health and well-being of vulnerable people. MLP lawyers are able not only to enforce these laws for patients, but also to help patients navigate

complicated bureaucracies that can feel overwhelming or impenetrable to families working on their own (13). In providing free legal representation to low-income families in these areas of law, MLPs reduce stress on families and alleviate conditions of poverty. This reduction in stress and alleviation of the conditions of poverty may in turn help prevent child maltreatment.

Some MLPs go beyond providing direct legal representation to clients and work to address health-harming policies as well (1). For example, one MLP provided comments to the Social Security Administration regarding revisions to the disability eligibility requirements (20). The Pediatric Advocacy Clinic at the University of Michigan Law School has worked with the Michigan Department of Health and Human Services to ensure that Medicaid Health Plans in Michigan have language in their manuals that conforms to the guarantees of federal Medicaid laws for children. And another MLP documented the health impacts of utility shut-offs on its patient population and successfully advocated for changes to the state regulations governing shutoffs (3).

Empirical support for MLPs

Empirical research into the effectiveness of MLPs at improving health outcomes is promising, though limited in scope. In a 2017 meta-analysis reviewing peer-reviewed research about MLPs from 1993-2016, a research team led by Temple University Professor Oscar Martinez found 13 studies with quantitative analysis of MLPs' impact (21). Of those, four incorporated pre-test and post-test data (21). Small pilot projects and studies identified in the meta-analysis have revealed favorable signs about MLPs' impact on health outcomes. In one example, an MLP improved asthma control. Asthmatic patients seen in a New York City teaching hospital lived in inadequate housing, with leaks, mold, and cockroach and rodent infestations exacerbating their symptoms. MLP attorneys assisted patients in securing necessary maintenance and structural repair to their homes, leading to improved asthma control, which manifested in a 90% decrease in emergency department visits and hospital admissions. Additionally, improved housing conditions led to the elimination of prescription systemic steroids, associated with a myriad of adverse effects, in 73% of the patients (22). In another example, low-income families with newborns who were randomly assigned a care team that included an MLP staff member demonstrated improved access to concrete supports, higher rates of on-time immunizations and preventative care, and less emergency department utilization relative to a control group (23). A third study evaluating a pilot program focused on "super-utilizers" of hospital services demonstrated decreases in both 30-day and seven-day readmission rates when the interdisciplinary care team addressed the patient's civil legal problems (24). The Robert Wood Johnson Foundation's County Health Rankings and Roadmaps program, which assigns "evidence ratings" to different medical interventions indicating their level of scientific support, gave MLPs its second-highest classification, reserved for strategies that are "likely to work, but further research is needed to confirm effects" (25). These strategies have been tested more than once and results trend positive overall.

Multiple studies have also considered MLPs' impact on stress levels. An analysis of a University of Arizona MLP demonstrated significant improvements in patients' perceived stress score and well-being after receipt of legal intervention, reflected in notable decreases in patient caregivers' Perceived Stress Scale (PSS-10) scores and improvements in their Measure Yourself Concerns and Well-being (MYCaW) scores (26). The University of Arizona MLP

provided legal assistance to patients and their families on a wide array of civil legal issues, such as access to food assistance, family law matters, and access to social security benefits. A study of parental PSS-10 scores before and after their children received assistance from a Rutgers University-affiliated MLP showed drops in stress levels, though the change was more modest than in the Arizona study (27). Even so, the study supports the proposition that MLP assistance can reduce parent-reported stress arising from social determinants of health. As such, the study lends support to the importance of MLPs in improving overall child and family health and well-being (27).

MLPs' effect on stress has also been assessed in the context of specific health conditions: A New York-based MLP interviewed 20 of its cancer patients to understand the impact that MLP intervention had on their quality of life (28). Seventy-five percent of patients said that the legal services reduced stress, 50 percent said it had a positive effect on family or loved ones, 45 percent noted a positive effect on their financial situation, 30 percent said it helped them maintain treatment regimens, and 25 percent said the services helped them keep their medical appointments (28).

Taken together, this data lend strong support to the notion that MLPs provide much needed assistance and relief for low-income families and therefore could be well situated to prevent child maltreatment.

Using MLPs to address child maltreatment

Because the experience of child maltreatment has been shown to cause long-term negative health outcomes, and because child maltreatment is widely recognized as a public health problem (29), it is reasonable to explore whether MLPs could address child maltreatment in addition to other stressors on families. After all, medical providers, and pediatricians in particular, are on the front lines of identifying child abuse and neglect (3).

THE ROLE OF MEDICAL-LEGAL PARTNERSHIPS IN PREVENTING CHILD MALTREATMENT: ETHICAL CONSIDERATIONS

The defining feature of medical-legal partnership is its collaborative nature. Doctors, nurses, social workers, and lawyers in MLPs work together to address social determinants of health in the lives of their low-income patients and clients. Collaboration across disciplines requires careful consideration of each profession's code of ethics to ensure professional independence and to safeguard patient/client information (30, 31). Health care providers and MLP lawyers put systems in place that define the scope of their collaboration and provide for client consent to the necessary inter-professional communication.

Typically, in an MLP, the structure of the collaboration goes as follows: MLP lawyers train health care providers to identify health-harming legal issues. When the provider is meeting with a patient, the provider identifies the patient's potential legal issue and, with the patient's permission, refers the patient to MLP legal staff. The MLP conducts an intake to evaluate the patient's legal needs, the MLP lets the patient know whether it will accept the patient for representation, the MLP lawyer obtains permission from the patient to discuss their case with

medical providers, and communication with providers about the status and outcome of the patient's legal needs continues throughout the representation (3). Depending on the nature of the legal issue, medical providers and lawyers may collaborate quite closely throughout the case. For example, if a child has been denied Supplemental Security Income (SSI), the lawyer will work with the child's physician to understand the child's disabilities so that the lawyer may advance an argument to the Social Security Administration that the denial was in error. If a family's home has conditions – such as mold – that exacerbate a family member's asthma, the MLP lawyer might use medical records to demonstrate the harmful effects of the housing condition on the family member and might ask the physician to explain the connection between mold and asthma or allergies in court. And if a parent is experiencing domestic violence, the lawyer may rely on physician documentation of abuse to substantiate the client's claims. In each of these cases, the collaboration enhances the legal representation and, as a result, the patient's health and well-being.

In the case of child maltreatment, one can imagine a number of ways in which MLP lawyers might get involved. During an appointment, a provider might notice physical signs of abuse of a child or may learn of the possibility of abuse and neglect from listening to either the parent or child. If it were any other legal issue, the provider would obtain patient consent to speak to the MLP lawyer about what is going on and the interdisciplinary collaboration would begin. In an MLP, where the essence of the work depends on collaboration and communication, the possibility of intervening in an abuse and neglect case becomes complicated. The different ethical obligations of health care providers and lawyers are in tension in this context.

In an MLP, it is the patient or any family member of the patient, who becomes the “client” for purposes of legal representation. An MLP that is partnered with a children's hospital, for example, will address health-harming legal needs of a child patient by representing the parent of the child. This occurs because until children turn 18, parents hold the rights of their children in most contexts. The determination of who is the client has significant consequences for the lawyer's ethical obligations.

Lawyers have a duty of loyalty to their clients (32). Inextricably connected to this duty of loyalty is the duty of confidentiality (33). All information related to the lawyer's representation of the client must be kept confidential unless the client consents or unless one of the narrow exceptions apply (3). These exceptions include, for example, the ability to breach confidentiality to prevent death or bodily harm or to prevent or rectify fraud by the client. (3). In many legal cases in which an MLP is involved, this duty of confidentiality does not interfere with the inter-professional collaboration. Parents freely provide consent for their MLP lawyers to give information to, and receive information from, medical providers. They do this because it enhances the ability of their lawyers to work on their case and it strengthens the medical-legal partnership. If the lawyer learns information in the course of representing the client that the client does not want the lawyer to share with the healthcare provider, however, this could affect the quality of the partnership and possibly of the representation as well. This scenario is more likely to occur in a child abuse and neglect case than in other typical MLP cases.

The lawyer's duty of confidentiality, coupled with their duty of loyalty to a client, means that if a lawyer is representing a parent and learns of abuse or neglect of a child, in most states (with some exceptions) (34) the lawyer may not disclose that abuse and neglect to the medical providers who referred the parent to the MLP – or to anyone else – without the parent's permission (3). In contrast, medical providers are mandatory reporters of abuse and neglect (3, 34, 35). Failure to report suspected abuse or neglect to Children's Protective Services can have

significant negative consequences for healthcare professionals. These consequences may include civil and criminal liability for both the medical provider personally and for their employer as well as licensure complaints and penalties (36). This responsibility is not to be taken lightly.

If a medical provider sees signs of abuse in a child, or learns of potential abuse and neglect, should the provider make a referral to the MLP lawyer? If the provider decides to make the referral, who becomes the MLP client? If the provider refers the parent to the lawyer, the parent will become the MLP client. What if the patient is an adolescent and that adolescent confides abuse or neglect to the provider? Should the provider refer that adolescent to the MLP lawyer? Once the parent or child becomes the MLP client, all of the ethical obligations and protections – including the duties of loyalty and confidentiality – attach to that attorney-client relationship.

If a provider makes a referral to the MLP lawyer of either the parent or the child in a case of suspected child maltreatment, the lawyer would then represent the parent against allegations of abuse and neglect or the child against the parent. In so doing, the lawyer will become privy to confidential information regarding the parent's relationship with his/her child. Because of the lawyer's duty of loyalty and duty of confidentiality, assuming the parent would refuse to give the lawyer permission to discuss their case with the medical provider who is a mandatory reporter of abuse and neglect, the provider and the MLP lawyer will no longer be able to discuss the case. In fact, it is not a leap to imagine a medical provider being called upon to testify against a parent in an abuse and neglect case about bruises examined or stories of neglect heard. The MLP lawyer would be in the unfortunate position of cross-examining their medical partner in the course of representing the client.

MLPs depend on a cooperative relationship and on the exchange of information to be effective, and there are ethical constraints on both health care providers and lawyers in the abuse and neglect context (30). One researcher exploring the ethical tensions that could arise between doctors and lawyers has cautioned, “[de]spite the significant benefits of integrating the provision of legal services into the health care setting, such risks should be fully explored to avoid unintended consequences to these partnerships and the patients they serve” (30).

Seeking to avoid this tension, some MLPs explicitly decline to accept cases involving suspected abuse and neglect and attempt to limit mandated reporters' exposure to confidential or privileged information in this context. The University of Michigan Law School Pediatric Advocacy Clinic (PAC) for example, does not accept referrals for abuse and neglect cases to avoid the tension that they invariably cause between MLP providers and lawyers. The PAC goes so far as to instruct the social work intern conducting intakes to inform each family that the social worker is a mandatory reporter of abuse and neglect and thus, if the client is concerned about this, should request to complete their intake with a member of the MLP team who is not a mandatory reporter. Other MLPs treat social workers as part of the legal team and require them to adhere to attorney-client rules of confidentiality (3). Of course, while it may be possible to incorporate social workers working as part of the legal team into the law office of an MLP, the same is not possible with medical provider partners working in their health care setting (3). Such steps to protect this information underscore the difficulty of an MLP in successfully navigating an abuse and neglect case while keeping the partnership intact (30).

Because of these ethical tensions, despite the fact that child abuse and neglect is an adverse childhood experience that has negative long-term health consequences and therefore seems ripe for MLP intervention, MLPs do not typically provide direct representation to either parents or children once abuse or neglect has been identified in a family. An MLP may represent a parent

trying to shield her children from another parent in the domestic violence and child custody contexts, which can also cause ethical challenges along the same lines as abuse and neglect cases (3), but will typically not represent the parent accused of abuse or neglect.

MLPs are better suited to address child maltreatment in an “upstream” manner – by reducing overall stress on families, by helping families obtain additional financial resources, and by working on policies that prevent child maltreatment (10). These could include advocacy for all sorts of social and economic interventions that ease poverty, provide expanded access to health care, and reduces stress.

CONCLUSION

To the extent that medical-legal partnerships unite health care providers and lawyers to relieve stress on families and ease some of the conditions of poverty, they are a valuable preventative tool in addressing the scourge of child maltreatment. Ethical challenges may arise and complicate the collaboration between health care providers and patient families if MLPs provide direct representation to either children or parents in cases of suspected child maltreatment. MLPs are thus better equipped to address other family stressors that contribute to child maltreatment and to work on policy matters. Medical providers who are connected to an MLP may help prevent child maltreatment by making referrals for families who are struggling with conditions of poverty and unmet legal needs. By addressing social determinants of health and reducing stress on families, providers are working to prevent child maltreatment.

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