Georgetown Journal on Poverty Law and Policy
Volume XXXI, Number 1, Fall 2023

NOTES

Medical-Legal Partnerships as Tools to Reduce Child Welfare Contact: Shifting Health Care Providers from Sites of Surveillance to Sites of Support

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ABSTRACT

The child welfare system can have devastating short- and long-term impacts on children and families. Families experiencing poverty should be met with support rather than pushed into this potentially harmful system. Yet, when families with low incomes and Black families come into contact with health care providers, they are disproportionately funneled into the child welfare system due to existing policies that equate poverty with neglect, mandatory reporting requirements, and bias in reporting and investigating. This Note argues that medical-legal partnerships (MLPs) can counteract these trends and better support children and families. Because MLPs reduce families' barriers to access to justice and increase families' access to income, benefits, and stable housing, they are one tool to address the conflation of poverty and neglect. To best support families and act as a child welfare prevention tool, MLPs must be expanded and coupled with reforms to mandatory reporting to shift health care providers from sites of surveillance to sites of support.

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I. INTRODUCTION

Families with low incomes and Black families are disproportionately funneled into the child welfare system. This disparity is primarily due to existing policies that equate poverty with neglect, mandatory reporting requirements, and bias in reporting and investigating. This Note argues that medical-legal partnerships (MLPs) can counteract these trends and support children and families. Part II highlights the urgency of this issue, providing an overview of the significant short- and long-term harms of a child coming into contact with the child welfare system and of being removed from their family. Part III explains how poverty acts as a driver of child welfare involvement

through increased exposure of families with low incomes to mandatory reporters and the conflation of poverty with neglect. Part IV highlights how health care providers currently act as sites of family surveillance and separation due largely to mandatory reporting requirements, funneling Black families and families with low incomes into the child welfare system, and undermining families' relationships with health care providers. Part IV also highlights the ways in which MLPs promote families' financial stability through legal support for individual clients and advocacy for systemic change to increase access to income, benefits, and stable housing. Part V explains the ways in which MLPs reduce barriers to civil legal services that disproportionately keep families with low incomes, and especially Black families with low incomes, from needed legal assistance. Finally, Part VI offers policy recommendations to expand MLPs and reform mandatory reporting requirements so that MLPs can help shift health care providers from sites of surveillance to sites of support for families.

II. Harms Of Child Welfare Contact

A. Harms of Child Welfare Contact

Evidence suggests that a family's contact with a child welfare agency can have lasting negative effects on children and families, even when the child is not removed from their family. Angela Olivia Burton, Former Director of NYS Office of Indigent Legal Services, described an investigation by child protection services as "rupturing the village of the child's ecological system, which has ripple effects and brings not just stigma, but also fear and distrust, as it tears the fabric of a child's life and community."[1] Research similarly shows that child welfare investigations and interventions can be stressors for children which can lead to "toxic stress and harms to the child's health and development."[2]

B. Short-Term Harms of Child Removal

There are well-documented short-term harms to a child's health and well-being when a child welfare agency separates them from their family. Children removed from their families and placed in foster care may not only lose contact with their parents but also with their siblings, extended families, friends, schools, and communities.[3] Often, children experience significant instability and a lack of

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1. Hum. Rts. Watch & ACLU, "If I Wasn't Poor, I Wouldn't Be Unfit": The Family Separation Crisis in the US Child Welfare System 65 (2022), https://www.hrw.org/sites/default/files/media_2022/11/us_crd1122web_3.pdf.

2. *Id.* (citing Caitlin Papovich, *Trauma & Children in Foster Care: A Comprehensive Review*, Concordia St. Paul (July 10, 2019), https://www.csp.edu/publication/trauma-children-in-foster-care-a-comprehensive-overview/; Cali. Child Welfare Co-Investment P'ship, Understanding Trauma to Promote Healing in Child Welfare XVII (2019); Applying the Science of Child Development in Child Welfare Systems, Harv. Univ. Ctr. on Developing Child (2016), https://developingchild.harvard.edu/resources/child-welfare-systems/).

3. Shanta Trivedi, *The Harm of Child Removal*, 43 N.Y.U. Rev. L. & Soc. Change 523, 533 (2019) (citing Jason B. Whiting & Robert E. Lee III, *Voices from the System: A Qualitative Study of Foster Children's Stories*, 52 Fam. Rel. 288, 292 (2003)).

stable relationships once removed from their families. For example, one study found that 20% of children were not in stable placements for the first year and a half they were in the custody of a child welfare agency.[4] Because of this separation from their communities and the lack of stability, children in the child welfare system often experience grief, distrust, and trauma that can lead to isolation, despair, low self-esteem, separation or attachment disorders, post-traumatic stress disorder, and anxiety.[5]

Family separation can cause devastating impacts on a child's short-term and long-term health.[6] Removal can lead to harms to children's physical health: it has been found that children's medical and dental conditions are "routinely ignored, under-identified, and untreated" when in foster care.[7] There is also evidence that children are more likely to be abused in foster care, so removal can put them at risk of greater trauma and abuse within their foster placements than any experiences of neglect they may have faced while with their parents or caregivers.[8] Removal can also lead to harms to children's mental health: children in foster care have an "increased risk for mental health disorders" and "higher rates of psychiatric problems" than those not in the child welfare system.[9]

C. Long-Term Harms of Child Removal

The negative harms of removing a child from their family can be long-lasting. Among children exiting foster care in Fiscal Year (FY) 2021, 64.9% had spent more than one year in foster care, and 16.9% of these children had spent more than three years in foster care.[10] 19,130—or 9%—of the children exiting foster care were exiting into emancipation, meaning they aged out of child welfare care without being reunified with their parents or other family members or being adopted.[11] Due to the lack of investment in cultivating relationships between children in foster care and supportive adults, "youth age out of care with limited

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4. *Id.* at 544 (citing David M. Rubin et al., *The Impact of Placement Stability on Behavioral Well-Being for Children in Foster Care*, 119 PEDIATRICS 336, 341 (2007)).

5. *Id.* at 532 (citing MONIQUE B. MITCHELL, THE NEGLECTED TRANSITION: BUILDING A RELATIONAL HOME FOR CHILDREN ENTERING FOSTER CARE 5 (2016)); Yael Cannon, *Unmet Legal Needs as Health Injustice*, 56 U. RICH. L. REV. 801, 838 (2022).

6. Trivedi, *supra* note 3, at 526–28; Lynn F. Beller, *When in Doubt, Take Them Out: Removal of Children from Victims of Domestic Violence Ten Years After Nicholson v. Williams*, 22 DUKE J. GENDER L. & POL'Y 205, 216 (2015).

7. Trivedi, *supra* note 3, at 546 (citing TASK FORCE ON HEALTH CARE FOR CHILDREN IN FOSTER CARE, AM. ACAD. OF PEDIATRICS, FOSTERING HEALTH: HEALTH CARE FOR CHILDREN AND ADOLESCENTS IN FOSTER CARE ix (2d ed. 2005)).

8. *Id.* at 542; Cannon, *supra* note 5, at 838.

9. *Trivedi, supra note 3*, at 549 (citing Peter J. Pecora, et al., *Mental Health Services for Children Placed in Foster Care*, 88 CHILD WELFARE 5, 10 (2009); Delilah Bruskas & Dale H. Tessin, *Adverse Childhood Experiences and Psychosocial Well-Being of Women Who Were in Foster Care as Children*, 17 PERMANENTE J. 131, 132 (2013)).

10. *The AFCARS Report: Preliminary FY 2021 Estimates as of June 28, 2022 - No. 29*, CHILDREN'S BUREAU 3 (2022), https://www.acf.hhs.gov/sites/default/files/documents/cb/afcars-report-29.pdf [hereinafter *AFCARS No. 29*].

11. *Id.*

connections and experience poor health, education, housing, and employment outcomes that could be mitigated by guidance and care from a strong, consistent support network."[12]

Child removal can negatively impact a child's future academic and financial outcomes. Those that experience foster care are more likely to drop out of school and less likely to graduate high school or college.[13] Former foster youth also experience higher rates of homelessness and criminal system involvement, are less likely to be employed, have lower annual earnings, and are less likely to be economically stable.[14] A 2010 longitudinal study of young adults who had been in foster care found that one third had incomes at or below the poverty line (compared to fifteen percent of the general adult population in 2010).[15]

Child removal and placement in the child welfare system also has lasting negative impacts on a child's health.[16] A 2014 analysis of longitudinal data found that young adults that were in foster care were at much greater risk of multiple adverse health outcomes later in life, associated with economic insecurity—including reports of fair or poor general health, hypertension, diabetes, smoking, ADHD, asthma, cardiovascular risk factor, and chronic health condition.[17] Doctors say the trauma of family separation can have long-term effects on children's brains and lead to catastrophic impacts on their adult health outcomes.[18] Former foster youth are more likely to experience psychological, emotional, and substance abuse problems.[19] A 2012 analysis of California Health Interview

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12. Hum. Rts. Watch & ACLU, *supra* note 1, at 119 (citing Rachel D. Rosenberg, *Strengthening Social Networks of Youth Aging Out of Foster Care: Promoting Positive Adult Outcomes*, VCU Scholars Compass (2018)); *see also* Laura Gypen et al., *Outcomes of Children Who Grew Up in Foster Care: Systematic-Review*, 76 Child. & Youth Servs. Rev. 74 (2017).

13. Trivedi, *supra* note 3, at 550–51 (citing Joseph J. Doyle Jr., *Child Protection and Child Outcomes: Measuring the Effects of Foster Care*, 97 Am. Econ. Rev. 1583, 1607 (2007); Catherine Roller White et al., *Alcohol and Drug Use Among Alumni of Foster Care: Decreasing Dependency Through Improvement of Foster Care Experiences*, 35 J. Behav. Health Servs. & Res. 419, 420 (2008); Mark E. Courtney et al., *Midwest Evaluation of the Adult Functioning of Former Foster Youth: Outcomes at Ages 23 and 24*, Chapin Hall 44–45, 95 (2010)).

14. *Id.*

15. *Id.* at 552 (citing Mark E. Courtney et al., *Midwest Evaluation of the Adult Functioning of Former Foster Youth: Outcomes at Ages 23 and 24*, Chapin Hall 44–45, 95 (2010)); *Income, Poverty and Health Insurance Coverage in the United States: 2010*, U.S. Census Bureau (Sept. 13, 2011), https://www.census.gov/library/publications/2011/demo/p60-239.html.

16. Cannon, *supra* note 5, at 838 (citing Kym R. Ahrens et al., *Health Outcomes in Young Adults from Foster Care and Economically Diverse Backgrounds*, 134 Pediatrics 1067, 1067 (2014), https://doi.org/10.1542/peds.2014-1150; Shanta Trivedi, *The Harm of Child Removal*, 524 N.Y.U. Rev. L. & Soc. Change 523, 547–48 (2019)).

17. Kym R. Ahrens et al., *Health Outcomes in Young Adults from Foster Care and Economically Diverse Backgrounds*, 134 Pediatrics 1067, 1070 (2014).

18. Trivedi, *supra* note 3, at 525 (citing William Wan, *What Separation from Parents Does to Children: 'The Effect Is Catastrophic*,' Wash. Post (June 18, 2018), https://www.washingtonpost.com/national/health-science/what-separation-from-parents-does-to-children-the-effect-is-catastrophic/2018/06/18/c00c30ec-732c-11e8-805c-4b67019fcfe4_story.html).

19. *Id.* at 550–51 (citing Joseph J. Doyle Jr., *Child Protection and Child Outcomes: Measuring the Effects of Foster Care*, 97 Am. Econ. Rev. 1583, 1607 (2007); Catherine Roller White et al., *Alcohol and Drug Use Among Alumni of Foster Care: Decreasing Dependency Through Improvement of Foster Care*

Survey data found that adults with histories of foster care involvement were more likely to report being unable to work for the past year, more likely to have physical or mental health concerns in the past month, and twice as likely to receive Social Security Disability because they were unable to work due to mental or physical health problems.[20]

D. Harms of Child Removal on Parents

Removing a child from their family disrupts a family's stability in ways that harm parents as well as children. Research has shown that child removal or custody loss can have a significant impact on parents' health and well-being.[21] For example, in interviews with Black parents in Florida who experienced separation from their children, common themes included overwhelming trauma, feelings of powerlessness and helplessness, isolation, and inadequate support systems.[22] Formal custody loss and inability to regain custody has resulted in increased maternal drug use as well as "long-term negative psychological, behavioral, and other health consequences."[23]

III. Poverty as a Driver of Child Welfare Involvement

A. Families with Low Incomes and Black Families are Overrepresented in Child Welfare

Poverty or economic instability is the leading cause of child removal.[24] Families experiencing poverty and living in low-income neighborhoods are more likely to be investigated for abuse or neglect, have their children removed from their care and placed in foster homes, and experience additional hurdles to being reunified with their children, especially when experiencing housing instability.[25] Even slight differences in income play a large role: "Families with incomes below

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Experiences, 35 J. Behav. Health Servs. & Res. 419, 420 (2008); Mark E. Courtney et al., *Midwest Evaluation of the Adult Functioning of Former Foster Youth: Outcomes at Ages 23 and 24*, Chapin Hall 44–45, 95 (2010)).

20. Cheryl Zlotnick et al., *Life Course Outcomes on Mental and Physical Health: The Impact of Foster Care on Adulthood*, 102 Am. J. Pub. Health 534, 537–38 (2012).

21. Cannon, *supra* note 5, at 838–39 (citing Sara E. Wakeman, Ayana Jordan & Leo Beletsky, *When Reimagining Systems of Safety, Take a Closer Look at the Child Welfare System*, Health Affs. (Oct. 7, 2020), https://www.healthaffairs.org/do/10.1377/hblog20201002.72121/full).

22. Effrosyni D. Kokaliari et al., *African American Perspectives on Racial Disparities in Child Removals*, 90 Child Abuse & Neglect 139, 143–45 (2019).

23. Kathi L.H. Harp & Carrie B. Oser, *A Longitudinal Analysis of the Impact of Child Custody Loss of Drug Use and Crime Among a Sample of African American Mothers*, 77 Child Abuse & Neglect 1, 7, 12 (2018); Cannon, *supra* note 5, at 838 (citing Sara E. Wakeman et al., *When Reimagining Systems of Safety, Take a Closer Look at the Child Welfare System*, Health Affs. (Oct. 7, 2020), https://www.healthaffairs.org/do/10.1377/hblog20201002.72121/full).

24. Trivedi, *supra* note 3, at 536 (citing Duncan Lindsey, The Welfare of Children 155 (2d ed. 2004)); Kathryn Joyce, *The Crime of Parenting While Poor*, New Republic (Feb. 25, 2019), https://newrepublic.com/article/153062/crime-parenting-poor-new-york-city-child-welfare-agency-reform).

25. *Id*; Katherine E. Marcel, *The Impact of Housing Instability on Child Maltreatment: A Causal Investigation*, 21 J. Fam. Soc. Work 331 (2018).

the federal poverty line are 22 times more likely to be involved in the child protective system than families with incomes slightly above it."[26] In a 2011 California birth cohort study, children who were eligible for the state Medicaid program were more than twice as likely to be reported for suspected maltreatment by age five, and children with mothers who had a high school education or less were more than six times more likely to be reported by age five than children with mothers who had a college degree.[27] Because of a long history of anti-Black policies and racial discrimination, Black children are nearly three times more likely to experience poverty than white children, making Black families more vulnerable to child welfare contact due to poverty or low income.[28] Black women are especially overrepresented in child welfare investigations and proceedings, often without legal representation.[29] In 2021, Black children accounted for 22% of children in foster care, despite making up 14% of all children.[30] This disparity exists despite studies showing either that there are no racial or ethnic differences in the occurrence of child maltreatment or that Black families have less risk of child maltreatment than white families.[31]

B. *Poverty and Low Incomes Increase Exposure to Mandatory Reporters*

A large factor in this race and income disproportionality is exposure to mandatory reporters. Families with low incomes are more likely to have contact with the public agencies and public service providers that are required to report suspected child abuse or neglect.[32] For instance, families with low incomes are more likely to access health care through public clinics or emergency rooms, live in public housing, use public transportation, and have a greater need for social services. [33] This tendency means that families with low incomes, and predominantly

26. Cannon, *supra* note 5, at 837 (citing Martin Guggenheim, *The Role of Counsel in Representing Parents*, AM. BAR ASS'N (Feb. 1, 2016), https://www.americanbar.org/groups/public_interest/child_law/resources/child_law_practiceonline/child_law_practice/vol-35/february-2016/the-role-of-counsel-in-representing-parents).

27. Kelley Fong, *Child Welfare Involvement and Contexts of Poverty: The Role of Parental Adversities, Social Networks, and Social Services*, 72 CHILD. & YOUTH SERVS. REV. 5, 5 (2017) (citing Emily Putnam-Hornstein & Barbara Needell, *Predictors of Child Protective Service Contact Between Birth and Age Five: An Examination of California's 2002 Birth Cohort*, 33 CHILD. & YOUTH SERVS. REV. 1337 (2011)).

28. Trivedi, *supra* note 3, at 537 (citing Dorothy Roberts, *Child Welfare and Civil Rights*, U. ILL. L. REV. 171, 176 (2003); DOROTHY ROBERTS, SHATTERED BONDS: THE COLOR OF CHILD WELFARE 29–30, 32 (2002)).

29. Cannon, *supra* note 5, at 839; Katherine Sabbeth & Jessica Steinberg, *The Gender of Gideon*, 69 UCLA L. REV. 1130, 1150–53 (2023).

30. *AFCARS No. 29*, *supra* note 10, at 2; *Child Population by Race and Ethnicity in the United States, 2021*, ANNIE E. CASEY FOUND. KIDS COUNT DATA CTR., https://datacenter.kidscount.org/data/tables/103-child-population-by-race-and-ethnicity#detailed/1/any/false/2048/68,69,67,12,70,66,71,72/423,424 (last updated Jul. 2023).

31. Kathy Lemon Osterling et al., *Understanding and Addressing Racial/Ethnic Disproportionality in the Front End of the Child Welfare System*, 5 J. EVIDENCE-BASED SOC. WORK 9, 13–14 (2008).

32. Fong, *supra* note 27, at 6.

33. Trivedi, *supra* note 3, at 537 (citing DOROTHY ROBERTS, SHATTERED BONDS: THE COLOR OF CHILD WELFARE 29–30, 32 (2002)); HUM. RTS. WATCH & ACLU, *supra* note 1, at 51 (citing Maria

Black families, have increased visibility to mandatory reporters and child welfare agencies.[34]

C. Poverty is Often Equated with Neglect

Physical and sexual abuse make up a small percentage of the circumstances associated with a child's removal (12% and 4%, respectively).[35] Instead, the majority of children removed from their families are removed due to neglect (63%).[36] The federal government defines neglect to include maltreatment but also negligent treatment, including failure to provide adequate food, clothing, shelter, or care;[37] therefore, poverty is often equated with neglect.[38] Housing instability and lack of reliable services and supports like child care or health care providers are often interpreted as parental unfitness or evidence of a family's inability to provide for their children.[39] For instance, in FY 2021, more than 19,000 children were removed from their families for housing-related issues.[40]

The Adoption Assistance and Child Welfare Act of 1980 requires that states make reasonable efforts to prevent children from being removed from their families;[41] however, states often fail to meet this mandate.[42] Research has found that the majority of children placed in foster care could have remained with their families without fear for their safety or well-being if families with low incomes received sufficient assistance to meet their basic needs.[43] In interviews with parents whose children were removed from their care, many participants expressed that they felt trapped by the constant lack of resources and forced to pick and choose which necessities to put their resources towards and which to sacrifice.[44] For instance, one parent "lost custody of her two older children as she tried to focus her limited resources on the three younger siblings by seeking

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Cancian et al., *The Effect of Family Income on Risk of Child Maltreatment*, INST. RSCH. POVERTY (2010), https://www.irp.wisc.edu/publications/dps/pdfs/dp138510.pdf).

34. HUM. RTS. WATCH & ACLU, *supra* note 1, at 51–52.

35. *AFCARS No. 29*, *supra* note 10, at 2.

36. *Id.*

37. 45 C.F.R § 1355, App. A, Sec. I (2022).

38. Trivedi, *supra* note 3, at 536 (citing Tanya Asim Cooper, *Racial Bias in American Foster Care: The National Debate*, 97 MARQ. L. REV. 215, 228 (2013); Christina White, *Federally Mandated Destruction of the Black Family: The Adoption and Safe Families Act*, 1 NW. J. L. & SOC. POL'Y 303, 314–15 (2006)).

39. HUM. RTS. WATCH & ACLU, *supra* note 1, at 95–96.

40. *AFCARS No. 29*, *supra* note 10, at 2.

41. Adoption Assistance and Child Welfare Act, Pub. L. No. 96-272 (1980) (codified as amended at 42 U.S.C. § 671).

42. Cannon, *supra* note 5, at 838 (citing *Reasonable and Active Efforts: A Tool to Prevent Removal and Reunify Families*, AM. BAR ASS'N. CTR. ON CHILD. & L. 1, 1–2 (2021); Raymond C. O'Brien, *Reasonable Efforts and Parent-Child Reunification*, 1030 MICH. ST. L. REV. 1029, 1059–60 (2013)).

43. *Id.* at 837-38 (citing Martin Guggenheim, *The Role of Counsel in Representing Parents*, AM. BAR ASS'N (Feb. 1, 2016), https://www.americanbar.org/groups/public_interest/child_law/resources/child_law_practiceonline/child_law_practice/vol-35/february-2016/the-role-of-counsel-in-representing-parents).

44. Kokaliari et al., *supra* note 22, at 143.

therapy for them—not imagining she would then lose her two oldest."[45] The U.S. Children's Bureau of HHS has even recognized the ways in which our current child welfare systems often equate poverty with neglect.[46] In a 2020 article, Associate Commissioner of the U.S. Children's Bureau Jerry Milner stated: "More times than not, poverty and struggles to meet the basic, concrete needs of a family are a part of the equation in all types of neglect" and rather than addressing root causes of families' inability to meet their basic needs, "we remain stuck as a system and society that focuses on the harmful aftereffects, often casting blame on vulnerable families for their very vulnerability."[47]

D. Poverty is a Barrier to Reunification

Poverty and economic instability also act as barriers to reunification of children with their families. For instance, many children remain in foster care solely because their family has inadequate housing, not because of any fears of abuse or mistreatment.[48] Interviews with parents whose children were removed from their care found that poverty and the resulting lack of sufficient housing, nutritious food, accessible healthcare, adequate transportation, and childcare services meant a decreased likelihood of reunification with their children.[49] Child welfare agencies may mandate adequate housing, attendance at court hearings, and therapy sessions as prerequisites for reunification, but poverty and low incomes create additional hurdles to meeting these requirements.[50] For example, parents may be unable to afford to make necessary changes to their housing or attend therapy sessions; poor transportation and inflexible jobs can keep parents from attending mandatory hearings or meetings; and missing work to attend hearings or meetings can result in further financial precarity and risks to job security.

IV. Mandatory Reporting Establishes Health Care Providers as Sites of Surveillance and Separation

A. Overview of Mandatory Reporting

The Child Abuse Prevention and Treatment Act (CAPTA), enacted in 1974, requires states to have provisions for mandatory reporting of suspected instances

45. *Id.*

46. *See* Jerry Milner & David Kelly, *It's Time to Stop Confusing Poverty With Neglect*, Imprint (Jan. 17, 2020), https://imprintnews.org/child-welfare-2/time-for-child-welfare-system-to-stop-confusing-poverty-with-neglect/40222. The Children's Bureau is an office of the Administration for Children and Families within the U.S. Department of Health and Human Services. The Children's Bureau seeks to improve the safety, permanency, and well-being of children and is primarily responsible for administering federal programs that support state child welfare services. *About*, Children's Bureau (June 28, 2023), https://www.acf.hhs.gov/cb/about.

47. Jerry Milner & David Kelly, *supra* note 46.

48. Trivedi, *supra* note 3, at 536–37 (citing Dorothy Roberts, Shattered Bonds: The Color of Child Welfare 21, 35 (2002); Martin Guggenheim, *Somebody's Children: Sustaining the Family's Place in Child Welfare Policy*, 113 Harv. L. Rev. 1716, 1724 (2000)).

49. Kokaliari et al., *supra* note 22, at 143.

50. *Id.*

of child abuse or neglect to receive federal grants. Since enacting these reporting laws, states have continued to expand the categories of people that are mandated reporters.[51] As of 2019, 18 states and Puerto Rico require universal reporting, in which every adult in the state is required to report suspected abuse or neglect, regardless of their profession, their familiarity with children, or their experience or knowledge regarding abuse and neglect.[52] Almost all states (approximately 47) require reporting by designated professions, including health care providers, social workers, teachers, school personnel, therapists, and law enforcement officers.[53] Requirements vary from state to state, but typically, a mandated reporter must make a report when they suspect or have reason to believe that a child has been abused or neglected.[54] As of 2019, 19 states and DC required mandated reporters to provide their names and contact information as part of their report, but most states permitted anonymous reports.[55]

Mandatory reporting requirements position medical professionals, as well as school staff, police, and social service agency staff, as the eyes and ears of child welfare agencies.[56] In 2020, child protection services (CPS) agencies received more than 3.9 million referrals alleging child abuse or neglect, the majority of which came from professionals (66.7%).[57] More specifically, legal and law enforcement personnel accounted for 20.9% of reports, education personnel accounted for 17.2%, and medical personnel accounted for 11.6%.[58]

Current mandatory reporting statutes cast wide nets to address a small percentage of cases involving abuse. It remains unclear how effective this wide-net approach is in preventing, identifying, and responding to incidents of child abuse or maltreatment.[59] Of the more than 3.9 million child abuse referrals in 2020,

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51. Dorothy Roberts, *How the Child Welfare System Is Silently Destroying Black Families*, IN THESE TIMES (May 24, 2022), https://inthesetimes.com/article/systemic-inequalities-in-the-child-welfare-system-target-black-families [hereinafter Roberts, *Silently Destroying Black Families*]. For a more detailed history of mandatory reporting statutes and CAPTA, *see* MICAL RAZ, ABUSIVE POLICIES: HOW THE AMERICAN CHILD WELFARE SYSTEM LOST ITS WAY 55 (2020); VICTORIA COPELAND & MAYA PENDLETON, UPEND, SURVEILLANCE OF BLACK FAMILIES IN THE FAMILY POLICING SYSTEM 7 (2022).

52. Child Welfare Information Gateway, *Mandatory Reporters of Child Abuse and Neglect*, CHILDREN'S BUREAU 3 (2019), https://www.childwelfare.gov/pubPDFs/manda.pdf; *see also* CHILDREN'S RIGHTS, FIGHTING INSTITUTIONAL RACISM AT THE FRONT END OF CHILD WELFARE SYSTEMS: A CALL TO ACTION 31 (2021), https://www.childrensrights.org/wp-content/uploads/2021/05/Childrens-Rights-2021-Call-to-Action-Report.pdf.

53. Child Welfare Information Gateway, *supra* note 52, at 2.

54. *Id.* at 3.

55. *Id.* at 5.

56. Frank Edwards, *Family Surveillance: Police and the Reporting of Child Abuse and Neglect*, 5 RUSSELL SAGE FOUND. J. SOC. SCIS. 50, 52 (2019), https://www.rsfjournal.org/content/rsfjss/5/1/50.full.pdf.

57. *Child Maltreatment 2020*, CHILD WELFARE INFO. GATEWAY xi, 8 (2020), https://www.acf.hhs.gov/sites/default/files/documents/cb/cm2020.pdf.

58. *Id.* at xi.

59. RAZ, *supra* note 51, at 55–56; Mical Raz, *Calling Child Protective Services is a Form of Community Police that Should be Used Appropriately: Time to Engage Mandatory Reports as to the Harmful Effects of Unnecessary Reports*, 110 CHILD. & YOUTH SERVS. REV. 1 (2020).

more than 1.8 million were screened out.[60] Of the more than 2.1 million referrals that were screened in, the majority (56.4%) were unsubstantiated, meaning there was not sufficient evidence to conclude or suspect that the child was maltreated or at risk of being maltreated.[61]

Following legislation expanding the list of professionals who are mandated reporters, Pennsylvania saw floods of unfounded reports that overwhelmed child protection agencies and disproportionately harmed families of color living in poverty.[62] There is no proof that the expansion of mandatory reporting prevented serious abuse cases.[63] In fact, experts suggest the expanded reporting requirements overburdened the system and made it more difficult to detect abuse or serious neglect and protect children who were truly in danger.[64] In the five years following the mandatory reporting expansion, Pennsylvania's hotline was inundated with more than one million reports of child abuse or maltreatment, but the overwhelming majority (more than 800,000 calls) were related to lower-level neglect allegations, often stemming from poverty.[65]

Between 2015 and 2019, the number of children reported as possible victims of abuse and serious neglect increased by 72% compared to 2010-2014.[66] However, of the nearly 200,000 allegations that led to CPS investigations between 2015 and 2019, county agencies dismissed the overwhelming majority (approximately 9 in 10) of the allegations as unfounded after inspecting families' homes and subjecting parents and children to questioning.[67] Sociologist Kelley Fong's field observations and interviews with mandatory reporters in Connecticut led her to the conclusion that professionals do not primarily report families to CPS to address imminent child safety concerns; instead, professionals often make CPS reports to address families' needs when families face adversity and the professionals are unable to intervene as they would like.[68]

B. Race and Income Disproportionality in Reporting and Investigating

Mandatory reporting requirements have been used as tools for surveillance and control of Black families, other families of color, and families with low

60. Child Maltreatment 2020, *supra* note 57, at 6–8. Reasons for screening out a referral vary but can include that the report did not concern child abuse or neglect, the report did not contain enough information for a CPS agency response to occur, a response by another agency is deemed more appropriate, or the children in the report are older than 18 years. *Id.*

61. *Id.* at 17, 20.

62. Mike Hixenbaugh et al., *Mandatory Reporting Was Supposed to Stop Severe Child Abuse. It Punishes Poor Families Instead*, ProPublica (Oct. 12, 2022, 8:00AM), https://www.propublica.org/article/mandatory-reporting-strains-systems-punishes-poor-families.

63. *Id.*

64. *Id*.

65. *Id.*

66. *Id.*

67. *Id.*

68. Kelley Fong, *Getting Eyes in the Home: Child Protective Services Investigations and State Surveillance of Family Life*, 85 Am. Socio. Rev. 610, 611 (2020).

incomes.[69] As discussed in Part III, low-income families and Black families are more likely to come into contact with mandated reporters, through accessing emergency rooms, public housing, and social services.[70] Public workers are more likely to report suspicions about their clients than workers in the private sector who serve wealthier, higher-paying clients.[71] Also, mandatory reporting requirements give significant discretion to service providers, leaving room for individual biases and subjective views of parenting when deciding whether to report a family of suspected abuse or maltreatment.[72]

Several studies have found that Black women and families are more likely to be reported to child welfare agencies by school staff, law enforcement personnel, and medical providers including obstetricians and pediatricians.[73] For instance, in FY 2019, education and law enforcement personnel were twice as likely to report Black families to child protective services than white families.[74] Similarly, a 2012 study found that prenatal providers identified Black women as using alcohol or drugs at similar rates to white women; yet, prenatal providers were more than four times as likely to report Black newborns to CPS for maternal alcohol or drug use than white newborns.[75]

Once reported to CPS agencies, cases involving Black children are also more likely to be investigated, confirmed, brought to court, and ultimately result in

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69. Roberts, *Silently Destroying Black Families*, *supra* note 51, at 4; CHILDREN'S RTS., FIGHTING INSTITUTIONAL RACISM AT THE FRONT END OF CHILD WELFARE SYSTEMS: A CALL TO ACTION 32 (2021), https://www.childrensrights.org/wp-content/uploads/2021/05/Childrens-Rights-2021-Call-to-Action-Report.pdf (citing Sarah E. Waken et al., *When Reimagining Systems of Safety, Take a Closer Look at the Child Welfare System*, HEALTH AFFS. (Oct. 7, 2020), https://www.healthaffairs.org/do/10.1377/forefront.20201002.72121/; *Our Systems Meant to Help Are Hurting Black Families*, NAT'L INST. FOR CHILDREN'S HEALTH QUALITY, https://www.nichq.org/insight/our-systems-meant-help-are-hurting-black-families); Mical Raz, *Unintended Consequences of Expanded Mandatory Reporting Laws*, 139 PEDIATRICS 1, 2 (2017)).

70. Roberts, *Silently Destroying Black Families*, *supra* note 51, at 5.

71. *Id.*

72. Lemon Osterling et al., *supra* note 31, at 13–14; Alan J. Dettlaff & Reiko Boyd, *Racial Disproportionality and Disparities in the Child Welfare System: Why Do They Exist, and What Can Be Done to Address Them?*, 692 ANNALS AM. ACAD. POL. & SOC. SCI. 253, 263–64 (Nov. 2020).

73. *See, e.g.*, Vincent J. Palusci & Ann S. Botash, *Race and Bias in Child Maltreatment Diagnosis and Reporting*, 148 PEDIATRICS 1, 1 (2021) (citing Marian S. Harris, *Racial Bias as an Explanatory Factor for Racial Disproportionality and Disparities in Child Welfare*, *in* RACIAL DISPROPORTIONALITY AND DISPARITIES IN THE CHILD WELFARE SYSTEM 141 (Alan J. Dettlaff, ed., 2021)); Sara E. Wakeman et al., *When Reimagining Systems of Safety, Take a Closer Look at the Child Welfare System*, HEALTH AFFS. (Oct. 7, 2020), https://www.healthaffairs.org/do/10.1377/hblog20201002.72121/full (citing Sarah C.M. Roberts & Amani Nuru-Jeter, *Universal Screening for Alcohol and Drug Use and Racial Disparities in Child Protective Services Reporting*, 39 J. BEHAVIORAL HEALTH SERVS. RES. 3 (2012)).

74. HUM. RTS. WATCH & ACLU, *supra* note 1, at 52. Education personnel reported Black children at a rate of 16.4 per 1,000 Black children, compared to white children at a rate of 8.6 per 1,000 white children. Law enforcement personnel reported Black children at a rate of 15.4 per 1,000 Black children, compared to 7.7 per 1,000 white children. *Id.*

75. Sarah C.M. Roberts & Amani Nuru-Jeter, *Universal Screening for Alcohol and Drug Use and Racial Disparities in Child Protective Services Reporting*, 39 J. BEHAV. HEALTH SERVS. RES. 3, 7–8 (2012).

child removal.[76] For instance, in FY 2019, Black children were subjected to investigation at a rate of 75.7 per 1,000 compared to a rate of 40.6 per 1,000 for white children, meaning they were 1.9 times more likely to be investigated.[77] A 2017 study similarly found that Black children were 1.75 times more likely to experience a maltreatment investigation than their white peers in 2014.[78] Looking at lifetime rates of investigation, an analysis of the 2003-2014 National Child Abuse and Neglect Data System Child Files found that more than half of all Black children experienced a CPS investigation by age 18, and Black children were nearly twice as likely to experience a maltreatment investigation in their childhood than white children (1.88 times more likely).[79]

The Children's Bureau has acknowledged that a variety of factors contribute to racial and ethnic disparities in the child welfare system, including institutional racism within child welfare agencies, disengagement of child welfare agencies from the communities they serve, policies and legislation that target families of marginalized racial and ethnic backgrounds, and a lack of policies that target the needs of families with marginalized racial and ethnic backgrounds.[80] The Children's Bureau has also acknowledged that racial bias and discrimination by individuals like mandated reporters and caseworkers contributes to racial disparities in child welfare.[81]

For example, healthcare professionals have been found to be more suspicious of Black families who bring their injured children to the hospital for care, regardless of the families' income level.[82] A 2018 study found that health care providers were almost twice as likely to report children of color with head injuries for abusive head trauma than they were to report white children with similar symptoms.[83] Mandatory reporting requires only a suspicion of child abuse or neglect. When determining if there is a suspicion of abuse or neglect and deciding whether to

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76. Palusci & Botash, *supra* note 73, at 1 (citing Child Welfare Information Gateway, *Racial Disproportionality and Disparity in Child Welfare*, CHILDREN'S BUREAU (2016), https://www.childwelfare.gov/pubPDFs/racial_disproportionality.pdf; Dorothy E. Roberts, *Child Protection as Surveillance of African American Families*, 36 J. SOC. WELFARE & FAM. L. 426 (2014)); Dettlaff & Boyd, *supra* note 70, at 254–55; Hyunil Kim et al., *Lifetime Prevalence of Investigating Child Maltreatment Among US Children*, 107 AM. J. PUB. HEALTH 274, 276 (2017).

77. HUM. RTS. WATCH & ACLU, *supra* note 1, at 58.

78. Kim et al., *supra* note 76, at 276 (6.59% of Black children experienced a CPS investigation in 2014, compared to 3.77% of white children, 0.85% of Asian or Pacific Islander children, 3.82% of Hispanic children, and 4.01% of Native American children).

79. *Id.* at 277-78. 53% of Black children experienced a CPS investigation by age 18, compared to 28.2% of white children, 32% of Hispanic children, 23.4% of Native American children, and 10.2% of Asian or Pacific Islander children. *Id.* at 277.

80. CHILD WELFARE INFO. GATEWAY, CHILDREN'S BUREAU, CHILD WELFARE PRACTICE TO ADDRESS RACIAL DISPROPORTIONALITY AND DISPARITY, 4–7 (2021), https://www.childwelfare.gov/pubpdfs/racial_disproportionality.pdf.

81. *Id.*

82. Roberts, *Silently Destroying Black Families*, *supra* note 51.

83. Child Welfare Information Gateway, *supra* note 80, at 6 (citing Hymel et al., *Racial and Ethnic Disparities and Bias in the Evaluation and Reporting of Abusive Head Trauma*, 198 PEDIATRICS 137 (2018)).

report a family to CPS, health care providers often rely on gut feelings which can be influenced by implicit biases.[84] This is supported by research finding that families' socioeconomic status, ethnicity, and culture influence mandatory reports from health care providers.[85]

C. Harms to Families' Relationships with Health Care Providers

Because mandatory reporting and child welfare contact is concentrated in low-income, predominantly-Black neighborhoods, family surveillance can negatively impact all families in these neighborhoods, even if they do not experience child removal or family separation themselves.[86] Mandatory reporting creates fear and distrust of health care providers and deters families from accessing needed assistance or supports for themselves and their children.[87] Scholar and child welfare abolitionist Dorothy Roberts has explained that mandatory reporting "thwarts the potential for schools, healthcare clinics and social programs to be caring hubs of community engagement that non-coercively help families meet their material needs."[88]

Through field observations and interviews in Connecticut, Kelley Fong found that mothers often expressed resentment, distrust, and hurt around reporting requirements, especially when reports were made by service providers with whom they had repeated contact and closer relationships.[89] One mother explained that after a prenatal clinic reported her for testing positive for cannabis during pregnancy, without giving her any notice of the need to report, she felt set up and like she couldn't trust the clinic staff anymore.[90] She explained that she was hesitant to speak openly with the clinic midwife since giving birth:

> It was certain stuff that I didn't wanna say to her because I didn't know if she's gonna go and tell. Like, I thought when I first had him that I was going through postpartum [depression]. I don't tell them how I

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84. Palusci & Botash, *supra* note 73, at 1 (citing Erik Stolper et al., *How Child Health Care Physicians Struggle from Gut Feelings to Managing Suspicions of Child Abuse*, 110 ACTA PAEDIATRICA 1847 (2021)).

85. *Id.* (citing Antoinette L. Laskey et al., *Influence of Race and Socioeconomic Status on the Diagnosis of Child Abuse: A Randomized Study*, 160 PEDIATRICS 1003 (2012); Vincent Palusci et al., *Hospital Experience Using Cultural Interpreters with the Orthodox Jewish Community*, 13 INT. J. CHILD HEALTH & HUM. DEV. 415 (2020)).

86. Dorothy Roberts, *The Regulation of Black Families*, REGULATORY REV. (Apr. 20, 2022), https://www.theregreview.org/2022/04/20/roberts-regulation-of-black-families/ (citing Dorothy Roberts, *The Racial Geography of Child Welfare: Toward a New Research Paradigm*, 87 CHILD WELFARE 125 (2008)).

87. *Id.* (citing Kelley Fong, *Getting Eyes in the Home: Child Protective Services Investigations and State Surveillance of Family Life*, 85 AM. SOCIO. REV. 610 (2020); Frank Edwards, *Family Surveillance: Police and the Reporting of Child Abuse and Neglect*, 5 RUSSELL SAGE FOUND. J. SOC. SCIS. 50 (2019), https://www.rsfjournal.org/content/rsfjss/5/1/50.full.pdf).

88. Roberts, *Silently Destroying Black Families*, *supra* note 51.

89. Fong, *supra* note 68, at 627.

90. *Id.* at 628.

> feel. I don't tell them any of that because I don't need them to say, oh, she's going through postpartum. She's gonna hurt the baby.[91]

In this case, fear and distrust of mandatory reporting prevented a mother from accessing additional health care services or support for her possible postpartum depression. Mandatory reporting and family surveillance can undermine families' trust in health care providers, prevent relationship-building between families and providers, and keep families from accessing health care services or support out of fear of encountering the child welfare system or having their child removed because they expressed a need for support.

V. MLPs as Tools to Reduce Child Welfare Contact

A. Access to Benefits, Income, and Housing Reduces Child Welfare Contact

Improving families' financial stability can help prevent contact with the child welfare system and the removal of children from their families.[92] For example, research has found an association between increased Earned Income Tax Credit (EITC) and Child Tax Credit (CTC) amounts and reductions in child protective services involvement and foster care entries.[93] A 2017 study of single-mother families with low incomes found that a $1,000 increase in income through the EITC was associated with an 8-10 percent decrease in child protective services involvement.[94] A 2022 study similarly found that "for each additional $1,000 in per-child EITC and CTC tax refunds," state-level rates of reported child maltreatment decreased by an estimated 5 percent.[95]

Similarly, there are indications that families' access to benefits is associated with reductions in child welfare contact.[96] For example, compared to those that did not receive nutrition assistance, families that accessed SNAP or WIC experienced reduced family poverty, reduced severity of food insecurity, and fewer CPS reports.[97] As another example, an analysis of restrictions on TANF between 2004

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91. *Id.*

92. Cannon, *supra* note 5, at 840 (citing Shanta Trivedi, *The Harm of Child Removal*, 524 N.Y.U. Rev. L. & Soc. Change 523, 527–28, 531–32, 536 (2019)).

93. Nicole L. Kovski et al., *Short-Term Effects of Tax Credits on Rates of Child Maltreatment Reports in the United States*, 15 Pediatrics 1, 2 (2022) (citing Lawrence M. Berger et al., *Income and Child Maltreatment in Unmarried Families: Evidence from the Earned Income Tax Credit*, 15 Rev. Econs. Household 1345 (2017); Whitney L. Rostand et al., *Reducing the Number of Children Entering Foster Care: Effects of State Earned Income Tax Credits*, 25 Child Maltreatment 393 (2020); Nicole L. Kovski et al., *Association of State-Level Earned Income Tax Credits with Rates of Reported Child Maltreatment, 2004-2017*, 27 Child Maltreatment (2022)).

94. *Id.* at 5 (citing Lawrence M. Berger et al., *Income and Child Maltreatment in Unmarried Families: Evidence from the Earned Income Tax Credit*, 15 Rev. Econs. Household 1345 (2017)).

95. *Id.* at 5.

96. *See, e.g.*, Henry T. Puls et al., *State Spending on Public Benefit Programs and Child Maltreatment*, 148 Pediatrics e2021050685 (2021).

97. Ctrs. Disease Control & Prev., Preventing Child Abuse and Neglect: A Technical Package for Policy, Norm, and Programmatic Activities 13, 16 (2016), https://www.cdc.gov/violenceprevention/pdf/can-prevention-technical-package.pdf (citing Bong Joo Lee & Lucy Mackey-

and 2016 found that states that imposed TANF restrictions saw increases in the number of substantiated cases of neglect, foster care placements, and foster care placements due to neglect.[98] On the other hand, the analysis found that easing a TANF restriction reduced the number of substantiated cases of neglect, number of children in foster care, and number of children in foster care due to neglect.[99] The study estimated that easing TANF restrictions could have resulted in more than 29,000 fewer children entering foster care in those twelve years.[100]

Programs that expand access to housing also have promising impacts on child welfare outcomes. Findings from a 2017 study on the impacts of the Family Unification Program (FUP) in Portland, OR and San Diego, CA suggest small reductions in both child removals and new reports of abuse or neglect among families that received housing vouchers.[101] Another study on FUP's impact in Chicago, IL similarly found small declines in out-of-home placements among families that received housing vouchers.[102] A 2012 study found that receipt of supportive housing services was associated with decreased child maltreatment reports, determinations of maltreatment, and out-of-home placements.[103] Although research remains fairly limited regarding the impacts of specific income and housing benefits on child welfare involvement, existing studies provide promising support that increasing families' financial and housing stability can help prevent child welfare contact and child removal.

Given the frequent contact between health care providers and families, health care providers have the potential to be important resources for families, connecting them to supports and services to promote their health and well-being. Yet, as discussed in Part IV, mandatory reporting requirements often force health care providers into surveillance roles and undermine the relationship between providers and families. This Part argues that, when coupled with reform to mandatory reporting, medical-legal partnerships (MLPs) can shift health care sites into sites of support—promoting families' financial stability and housing stability by reducing barriers to legal services; providing holistic, multi-disciplinary services

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Bilaver, *Effects of WIC and Food Stamp Program Participation on Child Outcomes*, 29 CHILD. & YOUTH SERVS. REV. 501 (2007)).

98. Donna K. Ginther & Michelle Johnson-Motoyama, *Associations Between State TANF Policies, Child Protective Services Involvement, and Foster Care Placement*, 41 HEALTH AFFS. 1744, 1751 (2022).

99. *Id.* (estimating that easing TANF restrictions could have resulted in more than 29,000 fewer children entering foster care during the 2004-2016 study period).

100. *Id.*

101. Michael Pergamit, et al., *The Impact of Family Unification Housing Vouchers on Child Welfare Outcomes*, 60 AM. J. COMM'Y PSYCH. 103 (2017).

102. Patrick J. Fowler et al., *Housing and Child Welfare: Emerging Evidence and Implications for Scaling Up Services*, 60 AM. J. COMM'Y PSYCH. 134, 139 (2017) (citing Patrick J. Fowler et al., *Homelessness in the Child Welfare System: A Randomized Controlled Trial to Assess the Impact of Housing Subsidies on Foster Care Placements and Costs*, 83 CHILD ABUSE & NEGLECT 52 (2017)).

103. Saahoon Hong & Kristy Piescher, *The Role of Supportive Housing in Homeless Children's Well-Being: An Investigation of Child Welfare and Educational Outcomes*, 34 CHILD. & YOUTH SERVS. REV. 1440, 1445–46 (2012).

for individual clients; and advocating for systemic change. By improving access to justice and promoting families' financial stability, MLPs can be used as tools to counter racial and socioeconomic bias and the conflation of poverty with neglect, which funnel families with low incomes, especially Black families with low incomes, into the child welfare system.

B. MLPs Place Legal Providers in Health Care Settings

Many individuals and families who access health care through health centers have unmet health-harming civil legal needs—an estimated 50-85% of health center users.[104] These legal needs can look like poor housing conditions such as mold or lead, cuts to SNAP benefits, loss of Medicaid coverage, denial of Supplemental Security Income (SSI) benefits, or lack of special education services at school. Medical legal partnerships (MLPs) are a growing model to promote early detection and treatment of these civil legal needs.[105] MLPs have increased to over 300 health care organizations in 41 states, including 1 in 5 children's hospitals in 2017.[106]

Through an agreement between a health care organization and a legal service provider, MLPs embed legal aid professionals into a health care setting in order to provide holistic support for patients and address health-harming legal needs.[107] MLPs typically serve patients with low incomes, but some MLPs are more narrowly focused on patients with specific conditions or characteristics.[108] For example, Georgetown University Health Justice Alliance's Cancer Legal Assistance & Well-being (LAW) Project serves patients with cancer, and the Medical-Legal Partnership for Seniors (MLPS) in San Francisco and Aging Right in the Community (ARC) in Boston serve older adults.[109]

MLPs use screening tools to help health care providers identify patients' health-harming legal needs across income, housing, utilities, education, and

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104. Bharath Krishnamurthy et al., *What We Know and Need to Know About Medical-Legal Partnership*, 67 S.C. L. REV. 377, 378 (2016) (citing PETER SHIN ET AL., DEP'T OF HEALTH POL'Y, RCHN CMTY. HEALTH FOUND. RES. COLLABORATIVE, MEDICAL-LEGAL PARTNERSHIPS: ADDRESSING THE UNMET LEGAL NEEDS OF HEALTH CENTER PATIENTS, AT 1 (POL'Y RES. BRIEF NO. 18) (May 4, 2010)).

105. Jennifer Rosen Valverde, *Preparing Tomorrow's Lawyers to Tackle Twenty-First Century Health and Social Justice Issues*, 95 DENVER L. REV. 539, 568 (2018), https://digitalcommons.du.edu/cgi/viewcontent.cgi?article=1020&context=dlr.

106. Danya E. Keene et al., *Reducing the Justice Gap and Improving Health through Medical-Legal Partnerships*, 40 J. LEGAL MED. 229, 231 (2020) (citing Marsha Regenstein et al., *Commentary: Addressing Social Determinants of Health through Medical–Legal Partnerships*, 37 HEALTH AFFS. 378 (2018), https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2017.1264).

107. Marsha Regenstein et al., *Commentary: Addressing Social Determinants of Health through Medical–Legal Partnerships*, 37 HEALTH AFFS. 378–80 (2018), https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2017.1264.

108. *Id.* at 380.

109. *Cancer LAW Project*, GEORGETOWN UNIV. HEALTH JUST. ALLIANCE, https://www.law.georgetown.edu/health-justice-alliance/our-work/delivering-health-justice/cancer-law-project/. *The Role of Medical-Legal Partnerships for Socially Vulnerable Older Adults*, NAT'L CTR. FOR MEDICAL-LEGAL P'SHIP & NAT'L CTR. FOR EQUITABLE CARE FOR ELDERS 5 (2020), https://medical-legalpartnership.org/wp-content/uploads/2020/07/Elder-Fact-Sheet-July-2020.pdf [hereinafter *Socially Vulnerable Older Adults*].

employment through a "legal check-up."[110] Based on the results of this screening, health care providers then connect patients to the legal service providers.[111] Some MLPs rely on telephone consultations and follow up appointments to connect patients with legal professionals, but at many MLPs, lawyers are available on-site to offer quick responses to patients' needs.[112] This legal assistance includes consultation and advice as well as direct legal representation for individual patients.[113] Beyond direct legal assistance, MLPs also provide education and training to health care providers regarding health-harming social and legal needs. Finally, many MLPs use their experiences with individual patients to advocate for larger-scale policy changes, through a "patient to policy approach."[114] For example, the MLP at Erie Health Center created a multi-state coalition that successfully advocated for the Department of Housing and Urban Development (HUD) to update its public housing lead regulations.[115] The MLP then began advocating for federal legislation to require lead inspections of all federally-assisted housing units before families move in.[116]

C. MLPs Reduce Barriers to Access to Justice

Families with low incomes do not have adequate access to justice. Research has found that low-income households are less likely to seek legal assistance regarding legal problems like concerns about not being paid money owed to them.[117] Nearly three in four (74%) of households with low incomes experienced at least one legal problem, and more than one in three (39%) experienced at least five legal problems in the past year.[118] Despite this significant need, individuals with low incomes sought legal assistance for only one in four civil legal problems that impacted them substantially and did not get any or enough legal help for

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110. Yael Cannon, *Medical-Legal Partnership as a Model for Access to Justice*, 75 STANFORD L. REV. 73, 77 (2023).

111. Regenstein et al., *supra* note 107, at 380.

112. *Id.* at 340.

113. Elizabeth Tobin Tyler, *Aligning Public Health, Health Care, Law and Policy: Medical-Legal Partnership as a Multilevel Response to the Social Determinants of Health*, 8 J. HEALTH & BIOMEDICAL L. 211, 235 (2012).

114. Cannon, *supra* note 110, at 79; Dayna Bowen Matthew, *The Law as Healer: How Paying for Medical-Legal Partnerships Saves Lives and Money*, BROOKINGS INST. (2017), https://www.brookings.edu/wp-content/uploads/2017/01/es_20170130_medicallegal.pdf.

115. Bethany Hamilton, Co-Director of National Center for Medical Legal Partnerships, Moving Upstream to Address SDOH and Health Equity at a Policy Level (Apr. 6, 2021), https://medical-legalpartnership.org/wp-content/uploads/2021/04/Toolkit-Webinar-5-slides.pdf.

116. *Id.*

117. *See, e.g.*, Rebecca L. Sandefur, *The Importance of Doing Nothing: Everyday Problems and Responses to Inaction*, *in* TRANSFORMING LIVES: LAW AND SOCIAL PROCESS 112, 115 (Pascoe Pleasence, Alexy Buck, & Nigel J. Balmer eds., 2007) (citing Consortium on Legal Services and the Public, *Report on the Legal Needs of the Low-Income Public*, AM. BAR. ASS'N (1994); Consortium on Legal Services and the Public, *Report on the Legal Needs of the Moderate-Income Public*, AM. BAR. ASS'N (1994)).

118. LEGAL SERVS. CORP., THE JUSTICE GAP: THE UNMET CIVIL LEGAL NEEDS OF LOW-INCOME AMERICANS 8 (2022), https://lsc-live.app.box.com/s/xl2v2uraiotbbzrhuwtjlgi0emp3myz1.

most (92%) of their substantial civil legal problems.[119] Perceived or actual costs of legal assistance tend to be the most common barrier to seeking legal help.[120] More than half (53%) of Americans with low incomes do not know if they would be able to find a lawyer that they could afford if they needed help with a serious civil legal problem.[121] Other reasons for not accessing legal assistance include having feelings of shame or embarrassment; believing they have insufficient power to succeed; feeling resigned following past experiences of frustration or failure in trying to resolve similar problems; not knowing where to look or what resources were available; believing that free or low-cost legal services are lower quality and will have long waiting times; and not being sure if the problem was a legal issue.[122] Because of these barriers, many individuals and families who access health care through health centers experience unmet legal needs that harm their health (an estimated 50-85 percent of health center users).[123]

MLPs are uniquely structured to reduce barriers to legal services because of their convenient location within an institution where families already have regular contact.[124] By embedding into health care settings, MLPs allow patients to be routinely screened for legal problems and connected to legal providers on-site.[125] MLPs often serve patients who would not have otherwise sought legal assistance due to lack of awareness of legal rights, difficulty locating services, inability to afford services, or lack of trust or familiarity with legal services.[126]

Not only do MLPs' locations reduce the physical and social barriers to accessing legal services, MLPs also promote contact between attorneys and those with legal issues further upstream. According to the Legal Services Corporation (LSC), the largest funder of civil legal aid for low-income Americans, LSC-

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119. *Id.*

120. *Id.*; Faith Mullen & Enrique Pumar, *The Community Listening Project*, DC CONSORTIUM OF LEGAL SERVS. PROVIDERS 30 (2016), https://www.lawhelp.org/files/7C92C43F-9283-A7E0-5931-E57134E903FB/attachments/A4B5C44F-8B88-4B76-97A9-FF648F7C7EB9/clp-final-april-2016.pdf; *Socially Vulnerable Older Adults*, *supra* note 109, at 2.

121. LEGAL SERVS. CORP., *supra* note 118, at 8.

122. Sandefur, *supra* note 117, at 123–27; *Socially Vulnerable Older Adults*, *supra* note 109, at 2; Diana Hernandez, *"I'm Gonna Call My Lawyer:" Shifting Legal Consciousness at the Intersection of Inequality*, STUD. L., POL., & SOC'Y 95, 108 (2010); Mullen & Pumar, *supra* note 120, at 30; LEGAL SERVS. CORP., *supra* note 118, at 8.

123. Krishnamurthy et al., *supra* note 104, at 378 (citing Peter Shin et al., Dep't of Health Pol'y, Rchn Cmty. Health Found. Res. Collaborative, Medical-Legal Partnerships: Addressing The Unmet Legal Needs of Health Center Patients (Pol'y Res. Brief No. 18), at 1 (May 4, 2010), https://hsrc.himmelfarb.gwu.edu/cgi/viewcontent.cgi?referer=&httpsredir=1&article=1006&context=sphhs_policy_ggrchn).

124. *Id.* at 239–40; Diana Hernandez, *"Extra Oomph": Addressing Housing Disparities through Medical Legal Partnership Interventions*, 31 HOUSING STUD. 871, 872 (2016); 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, 38 (2014); David I. Schulman et al., *Public Health Legal Services: A New Vision*, 15 GEO. J. POVERTY L. & POL'Y 729, 758 (2008).

125. Lawton & Sandel, *supra* note 124, at 38.

126. Keene et al., *supra* note 106, at 239–40 (citing Diana Hernandez, *"Extra Oomph": Addressing Housing Disparities through Medical Legal Partnership Interventions*, 31 HOUSING STUD. 871 (2016)); Marni von Wilpert, *Medical-Legal Partnerships in Mississippi: A Model to Improve Access to Justice*, 82 SUPRA 199, 211–12 (2013).

funded organizations turned away one out of every two (49%) of the 1.9 million requests for legal help they received in a year.[127] Because of the significant need and insufficient resources, legal service providers are forced to "triage," sorting requests into (1) those that receive direct representation, (2) those that receive brief advice or legal support, and (3) those that must be turned away with only basic information or referrals to other potential services based on the potential impact of the legal problems.[128] When individuals with low incomes are able to access legal assistance, it is usually through organizations that work to provide legal limited solutions to clients' problems rather than holistic support.[129] In MLPs, on the other hand, physicians can screen patients and act as an earlier point of contact for potential clients, promoting earlier intervention and prevention of legal crises.[130] For example, MLPs can prevent an eviction or a job loss due to a disability or medical illness. Through regular contact and legal check-ups as well as relationship-building during visits to health care settings, patients referred to an MLP for a single legal issue are better able to receive legal assistance for other issues simultaneously or as they arise over time. This model can better serve patients' and communities' needs as families living in poverty often experience two or three unmet legal needs at a given time.[131] At the Health Law Partnership (HeLP) in Georgia, for example, most clients report between two and five different legal issues affecting the family or child's health and well-being during their legal check-up in the intake process.[132] In traditional lawyer-client relationships, discussing legal problems with a legal professional is often costly; MLPs, on the other hand, allow participants to ask legal professionals questions regarding multiple legal issues and get information and advice that often empowers them to resolve their legal issues.

D. MLPs Increase Access to Stable Housing, Benefits, and Income

MLPs reduce barriers to legal support and help families address poor housing conditions, prevent housing instability, and secure benefits to which they are entitled.[133] For example, a 2016 study found that MLP interventions helped to ensure

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127. *The Justice Gap: Executive Summary*, LEGAL SERVS. CORP. (2022), https://justicegap.lsc.gov/resource/executive-summary/.

128. Erika Rickard, *Triage and Justice for All*, A2J LAB (Sept. 23, 2016), https://a2jlab.org/triage-and-justice-for-all/; LEGAL SERVS. CORP., *supra* note 118, at 73–74.

129. Stacy L. Brustin, *Legal Services Provisions through Multidisciplinary Practice – Encouraging Holistic Advocacy While Protecting Ethical Interests*, 73 U. COLO. L. REV. 787, 789 (2002).

130. Von Wilpert, *supra* note 126, at 213–14; MaryBeth Musumeci, *Augmenting Advocacy: Giving Voice to the Medical-Legal Partnership Model in Medicaid Proceedings and Beyond*, 44 U. MICH. J. L. REFORM 857, 893 (2011).

131. Andrew F. Beck et al., *Identifying and Treating a Substandard Housing Cluster Using a Medical-Legal Partnership*, 130 PEDIATRICS 831, 832 (2012).

132. Robert Pettignano et al., *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, 66–67 (2014).

133. Hazel Genn, *When Law is Good for Your Health: Mitigating the Social Determinants of Health through Access to Justice*, 72 CURRENT LEGAL PROBS. 159, 164-65 (2019).

adequate, affordable, and stable housing through a variety of housing resolutions, including securing utility shut-off protection, assisting in obtaining or retaining housing benefits, assisting with mediation in pending evictions, and securing shelter or permanent housing placement for participants that were unhoused.[134] Several studies have also found positive impacts on MLPs participants' income and access to benefits. For example, a 2012 follow-up study of an MLP in rural Illinois found that the MLP helped to relieve $4,000,000 in patients' health care debt and secure $2,000,000 in additional Social Security benefits for patients.[135] A 2013 study found that over three years, HeLP in Georgia recovered $300,000 in back benefits for participating families.[136] A 2015 randomized control trial involving families with infants found that families who received MLP intervention had significantly greater access across eight resources: a local food pantry or food program, SNAP, WIC, discounted telephone service, low-income utility discounts, Emergency Aid to the Elderly, Disabled, and Children (EAEDC), and Transitional Aid to Families with Dependent Children (TAFDC).[137] Similarly, a 2010 study of the Peninsula Family Advocacy Program in California found significant increases in the use of food and income supports following MLP participation: receipt of WIC increased from 32.5% to 50.0%, SNAP increased from 13.0% to 29.6%, SSI increased from 5.6% to 16.7%, and child support increased from 7.4% to 16.7%.[138] These benefits can have significant financial impacts on families. For example, for families supported in obtaining or retaining public benefits, the average amount of benefits received was nearly $400 per month.[139] For children who obtained appropriate educational accommodations through the MLP, the average value of education service obtained or retained was $12,000/month or $144,000 annualized total.[140]

134. Hernandez, *supra* note 124, at 879.

135. Tishra Beeson et al., *Making the Case for Medical-Legal Partnerships: A Review of the Evidence*, NAT'L CTR. MED.-LEGAL P'SHIP 5 (2013), http://medical-legalpartnership.org/wp-content/uploads/2014/03/Medical-Legal-Partnership-Literature-Review-February-2013.pdf (citing James A. Teufel et al., *Rural Medical-Legal Partnership and Advocacy: A Three-Year Follow-Up Study*, 23 J. HEALTH CARE FOR POOR & UNDERSERVED 705 (2012)).

136. Caitlin Murphy, *Making the Case for Medical-Legal Partnerships: An Updated Review of The Evidence*, 2013-2020, NAT'L CTR. MED.-LEGAL P'SHIP 4 (2020), https://medical-legalpartnership.org/wp-content/uploads/2020/10/MLP-Literature-Review-2013-2020.pdf (citing Melissa D. Klein et al., *Doctors and Lawyers Collaborating to HeLP Children: Outcomes from a Successful Partnership between Professions*, 24 J. HEALTH CARE FOR POOR & UNDERSERVED 1063 (2013)).

137. *Id.* (citing Robert Sege et al., *Medical-Legal Strategies to Improve Infant Health Care: A Randomized Trial*, 146 PEDIATRICS 97 (2015)).

138. Dana Weintraub et al., *Pilot Study of Medical-Legal Partnership to Address Social and Legal Needs of Patients*, 21 J. HEALTH CARE FOR POOR & Underserved 157, 164 (2010).

139. Robert Pettignano et al., *Medical-Legal Partnership: Impact on Patients with Sickle Cell Disease*, 128 Pediatrics e1482, e1486 (2011).

140. *Id.*

E. MLPs Advocate for Systemic Changes to Address Community Needs

As evidenced in Section D, MLPs help individual patients and families with low incomes address their health-harming legal needs, but they are also able to detect and address systemic failures and legal needs of communities.[141] MLPs use a patient-to-policy approach where the experiences of individual patients can serve as diagnostic tools to identify enforcement issues or policies that have negative health consequences.[142] MLP staff use their professional expertise, first-hand accounts of their experiences at the MLP, stories from patients, and medical evidence as tools to petition for more effective enforcement of laws and regulations that impact the health of people with low incomes; design long-term systematic solutions to policy or enforcement issues; and advocate policymakers for needed changes to address policy failures and promote health justice.[143] For example, the Cincinnati Child Health-Law Partnership (Child HeLP) identified a pattern of poor housing conditions impacting patients' health and used legal advocacy to address systemic housing code violations that harmed child health and led to increased hospitalization for low-income and predominantly Black children with asthma.[144]

MLPs are also better able to use a "community lawyering" approach to collaborate with the clients and communities. In traditional legal services, the lawyer acts as "the voice" for the client and there is little power sharing between the lawyer and client.[145] The community lawyering approach, instead, seeks to address the imbalance of information and decision-making and to empower impacted clients and communities.[146] Because of their collaborative nature and integration into community locations, MLPs are better able to adopt a community lawyering approach, leverage community networks, and drive community-based change to address health-harming legal needs.[147] For example, the H.E.A.L. Collaborative, housed in Rutgers Law School's Education and Health Law Clinic, collaborates

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141. Elizabeth Tobin Tyler, *Medical-Legal Partnership in Primary Care: Moving Upstream in the Clinic*, 13 AM. J. LIFESTYLE MED. 282, 284–85 (2019).

142. Cannon, *supra* note 5, at 862–63; Krishnamurthy et al., *supra* note 104, at 386; Schulman et al., *supra* note 124, at 760; Tobin Tyler, *supra* note 113, at 237.

143. Tobin Tyler, *supra* note 113, at 237; Joel Teitelbaum & Ellen Lawton, *The Roots and Branches of the Medical-Legal Partnership Approach to Health: From Collegiality to Civil Rights to Health Equity*, 17 YALE J. HEALTH POL'Y L. & Ethics 343, 368–69 (2017); Cannon, *supra* note 5, at 862–63, 866 (citing Megan Sandel et al., *Medical-Legal Partnership: Strategies for Policy Change*, *in* POVERTY, HEALTH AND LAW: READINGS AND CASES FOR MEDICAL-LEGAL PARTNERSHIP 585 (Elizabeth Tobin et al. eds., Carolina Acad. Press 2011); *Story Series Features Teams that Took SDOH Problem-Solving from Patients-to-Policy*, NAT'L CTR. MED.-LEGAL P'SHIP (May 2, 2018), https://medical-legalpartnership.org/patients-to-policy; NAT'L CTR. MED.-LEGAL P'SHIP, WHOLE PERSON, WHOLE TEAM, WHOLE COMMUNITIES SUMMIT 8–10 (2019), https://medical-legalpartnership.org/wp-content/uploads/2019/09/2019-NCMLP-Summit-Agenda-FINAL.pdf).

144. Tobin Tyler, *supra* note 141, at 284–85 (citing Andrew F. Beck et al., *Identifying and Treating a Substandard Housing Cluster Using a Medical-Legal Partnership*, 130 PEDIATRICS 831, 832 (2012)).

145. Cannon, *supra* note 110, at 85.

146. Tobin Tyler, *supra* note 113, at 243-44.

147. *Id.*

with the community on education and advocacy initiatives.[148] In response to parental concerns about lead exposure, the Collaborative developed educational pamphlets on the health effects of lead exposure and the legal rights of parents regarding lead in the local school's water supply.[149] Other community projects have included educational one-pagers for health care providers on social service programs and eligibility requirements and an online database compiling hundreds of local programs to increase information and reduce fragmentation.[150]

Through direct services and collaborative systemic advocacy, MLPs improve the financial stability of individual clients and of communities. These benefits can help shift health care providers from sites of surveillance—targeting predominately Black families with low incomes and funneling families into the child welfare system through mandatory reporting requirements and policies that equate poverty with neglect—into sites of support where families can access needed income and housing supports to promote families' financial stability, health, and well-being.

VI. Policy Recommendations

"If we truly care about children and families, it's time to stop confusing poverty with neglect and devote ourselves to doing something about it." – Jerry Milner, Associate Commissioner, Children's Bureau[151]

MLPs are one tool to address the conflation of poverty and neglect. Although not comprehensive, the following section offers policy recommendations for health care providers to better use existing funding sources for MLPs, for advocates and policymakers to expand federal funding sources for MLPs, and for states to overhaul their mandatory reporting requirements. Growing the number of MLPs, increasing their reach, and improving mandatory reporting will enable MLPs to transform health care providers from sites of surveillance to sites of support for families with low incomes and prevent the funneling of families into the child welfare system due to experiences of poverty.

A. Health Care Providers Should Use Existing Federal Funding for MLPs

Health care providers can use existing federal funding sources to support the establishment or expansion of MLPS at their sites. First, qualified health centers should use "enabling services" funding to support MLPs under section 330 of the Public Health Services Act.[152] Section 330 of the Public Health Services Act provides federal funds to federally qualified health centers (FQHCs), which are health centers that serve medically underserved populations, accept all patients regardless of their ability to pay, and therefore receive enhanced reimbursement

148. Rosen Valverde, *supra* note 105, at 581.
149. *Id.*
150. *Id.*
151. Milner & Kelly, *supra* note 46.
152. 42 U.S.C. § 254b.

from Medicaid and Medicare as well as Health Resource & Services Administration (HRSA) grants.[153] Section 330 permits health centers to provide "enabling" or supportive services that are non-clinical but can improve patient health. In a 2014 policy guidance, HRSA clarified that this may include civil legal services.[154] HRSA further signaled support for financing MLPs through a June 2015 funding opportunity announcement that extended access to enabling services funding and allowed health centers to apply for additional funds to provide civil legal services.[155]

Second, Medicaid managed care organizations (MCOs) should use CMS's "in lieu of" financing to pay for the creation or expansion of MLPs. A 2016 CMS rule created new authority for Medicaid MCOs to offer "in lieu of services," alternative services from those traditionally covered under Medicaid state plans. The 2016 rule allows states to reimburse for services covered by an MCO even though the services are not explicitly covered as part of the state plan.[156] Under the 2016 rule, for a service to be an "in lieu of service," 1) the state must determine that the alternative service is a medically appropriate and cost-effective substitute for the covered service, 2) the authorization must be expressly written in the contract with a list of the "in lieu of services" approved, 3) enrollees must not be required to use the alternative service, and 4) the utilization and cost of the "in lieu of services" must be taken into account when developing the capitation rates for the covered state plan services.[157] Through this rule, states have an opportunity to cover MLP services that are medically necessary to improve patient health as "in lieu of services."[158]

B. Congress Should Expand Federal Funding for MLPs

Congress should expand federal grants for the creation and expansion of MLPs. In the FY 2023 omnibus appropriations bill passed in December 2022, Congress included funding for a $2 million MLP grant program.[159] The program will award grants to multidisciplinary teams addressing medical and legal problems that have an impact on overall health, with a preference for minority-serving institutions.[160] This is the first federal legislation to provide funding expressly

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153. Bowen Matthew, *supra* note 114, at 35.

154. *Id.*; HEALTH RES. & SERVS. ADMIN., *Service Descriptors for Form 5A: Services Provided* 27, https://bphc.hrsa.gov/sites/default/files/bphc/compliance/form-5a-service-descriptors.pdf.

155. Bowen Matthew, *supra* note 114, at 35; HRSA-15-153, *Fiscal Year 2015 Affordable Care Act (ACA) Health Center Expanded Services Supplemental Funding Opportunity,* HEALTH RES. & SERVS. ADMIN. (2015), https://bphc.hrsa.gov/programopportunities/fundingopportunities/ExpandedServices/esinstructions.pdf.

156. Bowen Matthew, *supra* note 114, at 36–37.

157. *Id.*

158. *Id.*

159. *Solomon Center, Rep. DeLauro Help Secure Funding for Medical-Legal Partnerships*, YALE L. SCH. (Feb. 10. 2023), https://law.yale.edu/yls-today/news/solomon-center-rep-delauro-help-secure-funding-medical-legal-partnerships.

160. *Id.*

dedicated to MLPs.[161] The grant program is historic, but Congress can strengthen its impact by increasing the grant's funding and enabling a greater reach.

Congress can also provide federal funds under Title IV-E of the Social Security Act—for foster care, prevention, and permanency—to support MLPs that serve children and families. The most recent child welfare legislation, Family First Prevention and Services Act (FFPSA), incentivizes states to fund services that prevent child removal, shifting spending priorities from maintaining foster care to serving children in their families.[162] However, FFPSA limits funding to services and programs focused on mental health services, substance abuse prevention and treatment services, and in-home parent skill-based programs.[163] Also, FFPSA funnels prevention funding through CPS agencies and requires children to be identified as "candidates for foster care" and families to be referred by CPS agencies to access these services.[164] By providing Title IV-E funding for MLPs, Congress can support prevention efforts that do not push families into contact with child welfare agencies to access needed supports and services.

Congress can also increase federal funding under Title IV-B of the Social Security Act to support the creation and expansion of MLPs. While Title IV-B makes up a much smaller percentage of federal child welfare funding than Title IV-E (4% compared to 58%), Title IV-B funding has much greater flexibility.[165] There are no federal eligibility rules for recipients of Title IV-B funding so states can choose how to use these funds to support families at risk of child welfare involvement and promote the well-being of children.[166] By increasing available funding under Title IV-B, Congress will enable states to expand tailored prevention strategies, including MLPs.

Finally, Congress can also increase federal funding for the Social Services Block Grant (SSBG) to support MLPs. SSBG provides states with funding for five statutory goals, including preventing child neglect and abuse and promoting economic self-support.[167] However, the amount of money states receive is capped at a level that Congress determines each year.[168] By increasing the funding ceiling for SSBG, Congress can enable states to create or expand MLPs to connect

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161. *Id.*

162. Bipartisan Budget Act of 2018, Pub. L. No. 115-123, 132 Stat. 64, 232-69; s*ee also* Brianna Harvey, Josh Gupta-Kagan & Christopher Church, *Reimagining Schools' Rule Outside the Family Regulation System*, 11 COLUM. J. RACE & L. 1, 21–22 (2021).

163. Bipartisan Budget Act of 2018, *supra* note 162, at 232-269; *see also Family First Prevention and Services Act*, NAT'L CONF. STATE LEGISLATURES (last updated Apr. 26, 2022), https://www.ncsl.org/human-services/family-first-prevention-services-act.

164. Harvey et al, *supra* note 162.

165. *See* 42 U.S.C.§§ 620-629m; *Child Welfare Federal Funding Streams: Title IV-B*, CHILD. DEFENSE FUND (2022), https://www.childrensdefense.org/wp-content/uploads/2022/02/Child-Welfare-Federal-Funding-Streams-Title-IV-B.pdf.

166. CHILD. DEFENSE FUND, *supra* note 165.

167. ADMIN. CHILD. & FAMILIES, SOCIAL SERVICES BLOCK GRANT FISCAL YEAR 2020 ANNUAL REPORT 4 (2022), https://www.acf.hhs.gov/sites/default/files/documents/ocs/RPT_SSBG_Annual%20Report_FY2020.pdf.

168. *Id.* at 5.

families to legal services, increase financial stability, and prevent child welfare contact.

C. *MLPs Should Seek Non-Governmental Funding*

In addition to federal funding, advocates can also seek health care funding, philanthropic support, or law school partnerships to support the creation or expansion of MLPs.

In 2019, more than half (54%) of all health care organizations with MLPs included funding for the MLP in their operating budget.[169] In addition to highlighting the positive impacts of MLPs on patient health outcomes and the potential for MLPs to reduce families' contact with the child welfare system, advocates can also make a strong cost-saving argument for MLPs when seeking health care funding. For example, a study of four MLPs found that each program successfully leveraged health care recovery funds—reimbursed funds to clinical settings as a result of improperly denied Medicaid or Social Security Disability claims—which provided a direct financial benefit for the hospital or health care institution.[170] A study of an MLP serving cancer patients found the MLP generated nearly $1 million by resolving previously denied benefits claims.[171] Similarly, a study of a rural MLP in Illinois found the MLP generated a 319% return on the original investment of $116,250 over a three-year period, based on known health care recovery dollars.[172]

In 2019, 64% of MLPs received funding from national and regional foundations, private donations, and other forms of charitable giving.[173] Although philanthropic support is usually time-limited and therefore not a sustainable source of funding, philanthropy can be especially helpful to fund MLPs in their pilot stage and to fill funding gaps.[174] Advocates can point to the growing body of research demonstrating MLPs' positive impacts on individual patient health, community health, and legal outcomes and the ability to tailor MLPs to the specific needs of a community when seeking philanthropic funding.

As of 2019, 54 law schools—one in four—were involved in an MLP.[175] Law school partnerships have the potential to provide more sustainable funding streams and to increase MLPs' staffing and reach. Advocates can encourage more law schools to develop partnerships with MLPs by highlighting the academic benefits of the experiential learning opportunity as well as the impacts on

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169. Jennifer Trott et al., *Financing Medical-Legal Partnerships: View from the Field,* NAT'L CTR. MED.-LEGAL P'SHIP 1, 3 (2019), https://medical-legalpartnership.org/wp-content/uploads/2019/04/Financing-MLPs-View-from-the-Field.pdf.

170. Beeson et al., *supra* note 135, at 5.

171. Tobin Tyler, *supra* note 141, at 286 (citing Kerry J. Rodabaugh et al., *Medical-Legal Partnership as a Component of a Palliative Care Model*, 13 J. PALLIATIVE MED. 13, 15-18 (2010)).

172. James A. Teufel et al., *Rural Medical-Legal Partnership and Advocacy: A Three-Year Follow-Up Study*, 23 J. HEALTH CARE FOR POOR & UNDERSERVED 705, 710 (2012).

173. Trott, *supra* note 169, at 5.

174. *Id.*

175. *Id.* at 4.

health and legal outcomes. Academic MLPs provide interprofessional learning opportunities, build students' understanding of the social and structural factors that negatively impact clients' health and well-being, strengthen students' ability to collaborate across disciplines to solve problems, and bolster students' ability to reflect on their professional roles and responsibilities.[176]

D. States Should Reform Their Mandatory Reporting Requirements

The expansion of MLPs must be coupled with mandatory reporting reform in order for MLPs to best serve as tools to transform health care providers from sites of surveillance to sites of support and prevent families from coming into contact with the child welfare system. Ideally, mandatory reporting and mandatory investigation laws would be narrowed.[177] Reforms could look like limiting the types of professionals that are mandated reporters, increasing the level of suspicion required to trigger the mandate to report, loosening the negative consequences associated with not reporting, or requiring that families be connected to supportive services prior to or at the same time as a mandated report when neglect is expected due to experiences of poverty.

However, given the misconceptions regarding the efficacy of mandatory reporting and the political hurdles, significant reform might take years to achieve.[178] In the meantime, short-term improvements can also be made to reduce the harms of mandatory reporting on families with low incomes, especially Black families with low incomes.

First, states should provide clearer guidance regarding their existing mandatory reporting statutes. State mandatory reporting statutes typically require mandated reporters to make a report when they have a "reasonable belief" of abuse or maltreatment but tend not to provide clear guidance as to what constitutes maltreatment or a "reasonable belief."[179] These ambiguities leave mandated reporters to decide what might be reasonable without clear guidance or training—therefore, making decisions informed by bias, uncertainty, or a fear of consequences for not reporting.[180] States can update their statutes to distinguish between poverty and neglect and better define maltreatment and "reasonable belief" or issue guidance

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176. Vicki W. Girard et al., GEO. UNIV. HEALTH JUST. ALL. & NAT'L CTR. MED.-LEGAL P'SHIP, THE ACADEMIC MEDICAL-LEGAL PARTNERSHIP: TRAINING THE NEXT GENERATION OF HEALTH & LEGAL PROFESSIONALS TO WORK TOGETHER TO ADVANCE HEALTH JUSTICE 16 (2022), https://medical-legalpartnership.org/download/academic-mlp-report/.

177. For calls to end mandated reporting laws, *see* G. Inguanta & Catharine Sciolla, *Time Doesn't Heal All Wounds: A Call to End Mandated Reporting Laws,* 19 COLUMBIA SOC. WORK REV. 118, 130–31 (2021); Jeremy Loudenback, *Supporters, Not Reporters: Preventing Foster Care in California*, IMPRINT NEWS (May 16, 2023), https://imprintnews.org/top-stories/supporters-not-reporters-preventing-foster-care-in-california/241305; *Mandated Supporting*, JUST MAKING A CHANGE FOR FAMILIES, https://jmacforfamilies.org/mandated-supporting.

178. *See, e.g.*, Mike Hixenbaugh et al., *supra* note 62.

179. Miriam Itzkowitz & Katie Olson, *Closing the Front Door of Child Protection: Rethinking Mandated Reporting*, 100 CHILD WELFARE 77, 83–84 (2022).

180. *Id.*

to ensure clarity and consistency for mandated reporters regarding maltreatment and "reasonable belief."

Second, states should ensure adequate training for mandated reporters. Although CAPTA requires training for mandated reporters, few state statutes include specifications regarding training, and trainings can vary greatly between and within states.[181] Currently, trainings are often through online webinars or brief information lumped into broader onboarding training.[182] Trainings for mandated reporters should include clearer guidance regarding what constitutes "reasonable belief" and signs of maltreatment to reduce reports based on misunderstanding, uncertainty, and fear of negative consequences for not reporting. Regular implicit bias trainings should be required for mandated reports in order to reduce the influence of racial bias in reporting. Trainings should also include greater information regarding services and supports potentially available to families experiencing poverty to empower mandated reporters to connect families with services rather than to report families to child welfare agencies when they notice a financial need and do not know how else to address the need.

Finally, states should offer alternative channels for professionals to connect families to needed resources without child welfare contact. Advocates have begun calling for a shift from mandatory reporters to "mandatory supporters,"[183] and some cities and states have developed helplines or "warmlines" to offer support before a CPS hotline call is warranted.[184] The Children's Bureau has highlighted the strength of warmlines as a strategy to shift from surveillance to support of families.[185]

VII. Conclusion

The child welfare system has been proven to have devastating short- and long-term impacts on children and families. Families experiencing poverty should be met with support rather than pushed into this potentially harmful system. Because MLPs reduce families' barriers to access to justice and increase families' access to income, benefits, and stable housing, they are one tool to address the conflation of poverty and neglect. To best support families and act as a child welfare prevention tool, MLPs must be expanded and coupled with reforms to mandatory reporting to shift health care providers from sites of surveillance to sites of support.

181. *Id.* at 84.

182. *Id.* at 84–85.

183. Alexandria Ware, *Mandated Supporter, Not Mandated Reporter*, Children's Rts. (Feb. 9, 2023), https://www.childrensrights.org/news-voices/mandated-supporter-not-mandated-reporter.

184. *Transforming Child Welfare Systems: How Can Helplines Serve as a Better Pathway for Families to Access Support?*, Casey Fam. Programs (2020), https://www.casey.org/media/20.07-QFF-TS-Helplines.pdf.

185. Julie Fliss, *Doing Things Differently; Shifting from Cultures of Surveillance to Communities of Support*, Admin. Child. & Families (Apr. 3, 2023), https://www.acf.hhs.gov/blog/2023/04/doing-things-differently-shifting-cultures-surveillance-communities-support.