While medical and juvenile justice studies often report generic findings and recommend policies for “youth” or “adolescents,” recent studies indicate that adolescent girls and boys in the juvenile justice system are experiencing gender-specific health challenges and therefore should have gender-responsive health interventions (Acoca, 2000; Covington, 2007; Cauffman, et al., 2007). As they enter adolescence boys and girls health needs increasingly diverge. This has been particularly well documented in relation to mental health and it is true for girls and boys in the juvenile justice system are experiencing gender-specific health challenges and therefore should have gender-responsive health interventions (Acoca, 2000; Covington, 2007; Cauffman, et al., 2007). As they enter adolescence boys and girls health needs increasingly diverge.

Young men and women in the juvenile justice system have staggering and unmet health and mental health needs. While adolescent health issues cross all social and economic barriers, girls and boys who are involved with the juvenile justice system are at greater health risk for developing many chronic and urgent health problems than the general population of adolescents. Among the problems for which juvenile justice involved youth appear to be at increased risk are STDs, including HIV, alcohol and drug abuse, mental health disorders, asthma, dermatological, orthopedic and dental problems (Soler, 2002, Teplin, et al., 2002; Gupta, R.A., Kelleher, K.J., Cueller, A., 2005; Cauffman, et al., 2007).

While medical and juvenile justice studies often report generic findings and recommend policies for “youth” or “adolescents,” recent studies indicate that adolescent girls and boys in the juvenile justice system are experiencing gender-specific health challenges and therefore should have gender-responsive health interventions (Acoca, 2000; Covington, 2007; Cauffman, et al., 2007). As they enter adolescence boys and girls health needs increasingly diverge. This has been particularly well documented in relation to mental health and it is true for girls and boys in the juvenile justice system (Timmons-Mitchell, et al., 1997; Cauffman, et al., 2007). As one example, whereas both adolescent girls and boys who enter the

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FROM THE CHAIRS: TOP TEN REASONS TO TAKE A CHILD’S PRO BONO CASE

There are so many important causes and pro bono clients calling for the attention of the limited resources of volunteer attorneys. There is the increasing gap between rich and poor, the growing awareness of a lack of access to justice by a large percentage of the population, and the regretful circumstance of unfulfilled mandates in education, housing and safety. These challenges compete for the attention of all volunteer attorneys. Rather than suggesting that children’s law should be prioritized over any other area where pro bono volunteers can be helpful, the Children’s Rights Litigation Committee offers some information and insights about the work that can be accomplished by volunteer attorneys who choose children’s law projects. Some are obvious, some are less obvious. All these reasons reveal what children’s lawyers and advocates have come to know: that service to children brings tremendous rewards.

Children are fun clients.

Often child clients are not only gaining the benefit of your legal advocacy but they are learning about what a lawyer is, what a lawyer does and what the justice system promises. All of these experiences can enhance the role of the pro bono attorney as not only an advocate but a teacher and in some ways a mentor. What the lawyer gets back is a dynamic and downright fun relationship with a young mind.

Positive legal outcomes can significantly impact the lives of child clients

The legal system can have a dramatic impact on the lives of children. Take for example the child who is being represented in the juvenile justice system. The outcome of the case could provide them with a second chance. The child who faces expulsion from school could face the end of their education. A child in an immigration case may face torture or abuse if sent back to his or her home country. A child in an abuse and neglect case might linger in foster care without the advocacy of a lawyer. Lawyers can have an important impact on the lives of these young clients.

Children’s advocacy can be cutting-edge legal work

In many ways children’s law is very new and still developing. Our juvenile justice system, for example, born out of a criminal justice system that was begun by the nation’s founders, dates back only 40 years. The Child Protection System, though deep in the traditions of this democracy, is always changing and reinventing itself to try to better address the needs of abused, neglected and abandoned children and their parents. Laws that affect children in our immigration courts are adjusting rapidly to new legislation, policies and politics as the nature of our globalized world requires new and sometimes more complicated regulations about which children may enter our borders and which are unwelcome. This means that advocacy - trial, transactional, or appellate - can very often allow the advocate to be the first to interpret a statute or regulation. It can encourage unique arguments in a setting where the law has not yet been interpreted, or allow challenges to interpretations that have been developed through “assembly-line justice” in a system that is under-resourced and overburdened. A volunteer attorney with a fresh perspective can actually bring something quite new to the arena that changes and shapes the application of laws to children.

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juvenile justice system appear more likely than teenagers in the general population to have engaged in early sexual activity, and both genders are more likely to become “teen parents,” young women experience more serious reproductive health issues, including elevated rates of many STDs, and of course, only they become pregnant with all the attendant risks (Gallagher, C., Dobrin, A., & Douds, A., 2007). Many of the reproductive health issues facing these girls are highly correlated with sexual risk behaviors, substance abuse, school truancy, family violence and trauma including histories of sexual abuse, which are not addressed in the juvenile justice system (Covington, S., 2007; Kelly, P.J., et al, 2007). Conversely, males are still at greater risk of violent death, especially correlated with handgun ownership and violence.

The mental health needs of young men and women in the justice system have received recent attention. In her 2002 study, Teplin found that nearly two thirds of males and three quarters of females in the Cook County Juvenile Detention Center met criteria for 2 or more psychiatric disorders, primarily depression and anxiety disorders (Teplin, et al., 2002). In her 2007 study, comparing mental health by gender across matched groups of community and detained youth, Cauffman found that detained girls externalize their problems as well. She found that detained girls are twice as likely as boys to behave in an angry and irritable manner and just as likely as boys to have problems with alcohol or drug use (Cauffman, et al., 2007). In these girls, mental health issues (like physical health issues) are linked to high rates of childhood trauma, family chaos and residential instability. The lack of family and community connection that drives so many youth into the juvenile justice system is also a central feature of the juvenile justice system itself.

Recognizing the health needs of this population, the National Commission on Correctional Health Care (NCCHC), the Society for Adolescent Medicine (SAM), and the American Academy of Pediatrics (AAP) all have standards relating to providing health care to juvenile justice youth (including some specifically for girls) housed in detention or residential facilities (NCCHC, 2004; SAM, 2000; AAP, 2001). Moreover, systems are legally obligated to provide for youths’ health needs and protect them from harm when they are in institutions under the U.S. and state constitutions, case law, and statutes [e.g., United States Consti-


Yet, even while detained or in residential programs, when youth are in one place to receive health care and that care is mandated, few youth receive care that complies with existing standards (Gallagher, C.A. & Dobrin, A., 2007; Gallagher, C.A., Dobrin, A. & Douds, A.S., 2007).

Most attention has focused on health care for youth within detention and residential facilities, and there are few studies addressing access to health care among juvenile justice youth re-entering the community. However, it is generally acknowledged that, like adult inmates, youth re-entering the community from the juvenile justice system have difficulty accessing health care. The social and financial costs of this lack of access are significant. These youth are likely to use emergency departments for routine health care, they are likely to postpone care thereby aggravating routine health issues, and they are more likely to be re-incarcerated (Acoca, 2000; Moses, M. & Potter, R.H., 2007). From a public health perspective, without continuous health care these youth, who are at high risk for communicable diseases such as STDs, are likely to spread illness among their peers (Gupta, R.A., Kelleher, K.J., Cueller, A., 2005).

Upon re-entering the community, pre-existing impediments to health care continue to work against access. Girls and boys re-entering the community are disadvantaged in accessing health care by family chaos, frequent residential transitions, poverty, race, and inconsistent parenting. In addition, they confront a range of impediments that are imposed by public and private systems. The physical and mental health needs of youth in the justice system are not sufficiently understood. There is no gender-specific, culturally competent health screen administered to all youth when they enter detention or residential placement. Juvenile systems are structured so that youth cycle in and out of detention, community, and placement, routinely disrupting community services including health care. Medical records do not follow the youth and no one person or agency is responsible for coordinating care. Youth do not have ongoing relationships with health clinics or doctors unless they develop them before they enter

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the system, and those pre-existing treatment relationships rarely continue through a youth’s time in the system, which is marked by frequent transitions (Atkins, et al., 1999; Soler, 2002; Sherman, 2005).

State and community-based agencies providing mental and physical health services, and funding for those services, tend to function independently from each other, juvenile courts, and youth services departments. Public funding for health care may not be available to some youth and many youth who are eligible for Medicaid due to family income, lose that eligibility when they are incarcerated and have difficulty regaining Medicaid services when they re-enter the community and once again become eligible (Burrell, S. & Bussiere, A., 2002; Gupta, R. et al, 2005). Finally, there is general mistrust of systems among delinquent youth. Many youth involved in the justice system, particularly young women with significant needs, run from the system avoiding health (and other) services out of fear that health care providers are part of “one big system” which will incarcerate them.

While a juvenile’s time within a facility is an important opportunity to provide health care, long-term positive health outcomes depend on consistent health care that moves with young women and men when they re-enter the community. Meaningful health care access must be continuous, coordinated and lasting - linking youth to health homes in the community that will provide care to them and their children when they age out of the system and helping them acquire the skills to access that care for themselves and their families into adulthood. The call for coordinated, continuous care is not new and these elements have been a part of many of the most innovative rehabilitative and health programs for justice system youth over the past two decades (Soler, 2002; Covington, S., 2007).

Massachusetts Health Passport Project

The Massachusetts Health Passport Project (MHPP) is an expansion of a pilot program, which is facilitating continuous access to health care for girls (and now boys) in the juvenile justice system in Massachusetts. The project, which began in July, 2004 is a collaboration among the Massachusetts Department of Youth Services, the Juvenile Rights Advocacy Project at Boston College Law School and community health centers (Codman Square and Dorchester House in Boston and Great Brook Valley Health Center in Worcester).

The MHPP has four objectives:
- improving access to health care;
- changing relevant systems;
- improving youth’s social supports; and
- improving health status.

Through grant funds, a nurse (RN or NP) is hired by a community health center. That nurse is placed in the community re-entry center where Massachusetts youth committed to the Department of Youth Services and living in the community are required to report (as part of their juvenile parole). The nurse holds regular office hours and sees youth by appointment or drop-in. She provides minor medical care on-site, including pregnancy testing and reproductive health counseling for the girls. She is connected to the community health center remotely and helps youth identify a community health provider, make appointments, and keep those appointments; making every effort to support girls’ existing health care relationships and respect family decisions about their children’s care. When needed, she attends health appointments with the girls, modeling how to access and manage health care, and connects the girls to health related community services such as counseling and home visiting for parenting teens. The MHPP nurse traverses the systems, quarterbacking care. She works with DYS, community health care providers, and families to ease youths’ health care transitions as they move in and out of placement.

The MHPP Nurse has many roles. She serves as a direct service provider, active case manager, advocate within the justice system, health educator to the girls, health educator to justice system personnel, referral source, liaison between medical staff in lock-up, community justice staff and health care centers, and community health advocate (Miranda-Julian, C., Oliveri, R. & Jacobs, F. 2007). In addition to the nurse, the MHPP relies on critical collaborations with juvenile justice agencies, health care providers and philanthropy. These collaborators have participated in the MHPP Advisory Board, informed program planning, provided services to youth, technical support, and funding. The MHPP model does not create a new health care system, rather,

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it attempts to facilitate access across existing systems for youth whose personal circumstances provide significant impediments to continuity of care (Jacobs, L. & Jacobs, F. 2007).

The MHPP program models are built through ongoing consultation with evaluators from Tufts University. Recognizing that program models must be tailored to the needs and demands of each site, before expansion to a new site or population, the evaluation team conducts an assessment to determine how each population of youth will best receive MHPP services. Evaluation research will allow the MHPP to better understand key aspects of health access significant to the health and juvenile justice fields in and beyond Massachusetts.

Some of the questions MHPP evaluators hope to address are:

- What are the similarities and differences between the core needs and preferences for health care among system involved boys and girls?
- What are the processes by which various versions of the MHPP are delivered in different contexts?
- Within the MHPP communities, what factors (e.g. race, culture, ethnicity, family, involvement, geography, living situation) appear to or are reported to influence girls’ utilization of health care services?

Through our experience and research on best practices in correctional health (Oliveri, R. & Jacobs, F. 2007; View Associates, 2006) a set of core program elements is emerging:

- Nurse or NP with connections to local health resources is based at a community center frequented by justice system youth;
- Nurse or NP is employed by local community health center or hospital, not youth services department;
- Providers are culturally and gender competent;
- Parents and families are actively incorporated in health education and care;
- There needs to be ongoing communication between the youth services department medical services (inside facilities) and community health providers, through all residential transitions during the duration of the program;
- Youth are enrolled as soon as possible after commitment to the juvenile justice system;
- Partnerships with local health and service providers to build local supports are important;
- Youth services and social services’ staff should receive training in health and health access issues;
- Health education should be provided for youth; and
- There should be a proactive and preventative approach to health care.

**Policy and Program Issues**

**Health Care Funding**

Providing seamless Medicaid coverage for youth in the justice system and expanding that coverage to include case management services are important to providing continuous health care access to this population. Under the federal inmate exclusion rule, which denies coverage to anyone who is an “inmate of a public institution,” Medicaid does not support health care while youth are incarcerated or detained in the juvenile justice system. However, youth in Massachusetts regain Medicaid services immediately upon re-entry into the community. This is not so in most other states where youth in the juvenile justice system are Medicaid eligible only if they are income eligible. Typically, these youth not only lose services when they are incarcerated or detained, but in some cases they lose eligibility or have their eligibility suspended resulting in a delay in the resumption of benefits when they

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re-enter the community. That delay is either because the youth isn’t aware of his or her eligibility, doesn’t know how to apply for Medicaid, or because the process of applying takes time. This gap leaves many eligible youth without Medicaid services during their critical transition into the community (Burrell, S. & Bussiere, A., 2002; Gupta, et al., 2005; Moses, M. & Potter, H., 2007).

Even when Medicaid benefits are available, case management services such as those provided under the MHPP model are often not explicitly covered by state plans. Expanding Medicaid coverage to explicitly include case management for this population is critical for continuity and coordination of care. Legal strategies to access funding under Medicaid’s Early and Periodic Screening, Diagnosis and Treatment (EPSDT) provisions may be useful here. One promising example is the case of Rosie D. v. Romney (410 F. Supp. 2d 18, 2006) which held that Massachusetts violated the Medicaid Act by failing to offer adequate assessments, service coordination and in-home behavioral health services to children with Serious Emotional Disturbances (SED) who were entitled to community based health services under Medicaid’s EPSDT, “reasonable promptness” and “equal access” provisions. The remedial plan ordered by the court in July 2007 mandates extensive care coordination for SED youth receiving behavioral health services in the community.

Both the inmate exclusion rule and Medicaid’s EPSDT provisions suggest advocacy strategies to promote community health care access for girls and boys in the juvenile justice system. Youth in the juvenile justice system who live in the community (i.e., at home, in foster care, or in group care) as a disposition or while on probation or parole, are not excluded from Medicaid services under the inmate exclusion rule and, if otherwise eligible for Medicaid, remain entitled to those services. In light of this, and in light of the high public health costs to interrupted health care, Courts should be encouraged to order dispositions that maintain youth in the community with Medicaid services intact. Moreover, in cases of youth in the juvenile justice system with SED (which is likely to include many girls in the juvenile justice system), advocates and courts should develop plans for community behavioral health services rather than detaining or incarcerating girls in the hope that they will receive behavioral health care from within the justice system.

Gender-Responsive Service Delivery

There are important gender differences in the health needs, help-seeking behaviors, health care utilization, and types of health services available to system involved girls and boys. An effective health access program must be responsive to these differences, which are documented in the literature and in the MHPP evaluation (Oliveri, R. & Jacobs, F., 2007). For example, the evaluation found that there was a lack of health education and services for boys related to reproduction, sexuality and parenting, while these services were present for girls. The evaluators also found that boys in the justice system were more likely to let their injuries remain untreated longer than girls, reportedly because they feel they are able to take care of themselves without the help of others to a greater extent than did their female peers. While living in the community, girls saw health providers more frequently than boys did, perhaps due to routine gynecological visits or perhaps due to their reported interest in developing relationships with health care providers (Oliveri, R. & Jacobs, F., 2007). These differences underscore the need to tailor the health access program to each gender and within each gender, to the race and culture of participating youth.

Medical Consent and Confidentiality

For the most part, statutes and regulations governing consent to medical treatment for minors in state care and custody vary by state and may not explicitly cover all the situations that arise providing health care to these youth. It is critical that everyone involved in the health care of youth in the justice system understand the state laws of medical consent. For example, in many states teens can consent to testing and and treatment for specific communicable diseases, and girls are able consent to testing for pregnancy and STDs as well as reproductive health counseling. Moreover, juvenile justice systems, which typically do not have legal custody of youth when they are in the community (even when those youth are committed to their care and on parole in the community), are likely not to have authority to consent to the...
Access to Community Health Care (continued from page 6)

adolescent’s medical treatment. That authority probably remains with parents or the youth themselves.

Similarly, laws relating to confidentiality of medical, mental health and justice system information become important when coordinating care across juvenile justice and community health care systems. For example, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law governing confidentiality of health information through extensive regulations (45 C.F.R. parts 160 and 164). When minors are “individuals” under HIPAA, whether state agencies have authority to consent to release of minor’s protected health information, and whether juvenile justice agencies are HIPAA providers will depend on the particular situation and are all issues beyond the scope of this discussion, but are important to designing and delivering coordinated care and must be addressed by health access projects.

Conclusion

Case law and standards proscribe the minimum level of care required for girls and boys in the juvenile justice system as they do for adults in the correctional system. Yet, that minimum standard is often not met. In order to reduce future health costs and prevent a public health crisis as these youth re-enter the community, have children, and become adults, more than the minimum is required. Providing continuous and coordinated health care to girls and boys in the justice system, from incarceration or detention through re-entry into the community and until youth age out of the system, requires intentional collaboration among juvenile justice agencies and community health providers as well as case management across these systems. The MHPP is one example of a program designed to coordinate care, however, any health access program for youth in the juvenile justice system must be tailored to the system context. The health needs and preferences of youth in the juvenile justice system vary by gender and probably by race, culture, ethnicity, and family involvement. To be effective, health access projects must respond to those needs and preferences. Providing continuous, coordinated care to this high-risk population when they re-enter the community is a public health imperative. □

Francine T. Sherman serves as the director of the Juvenile Rights Advocacy Project and clinical professor at Boston College Law School. The Massachusetts Health Passport Project has been generously supported by the Jacob and Valeria Langeloth Foundation, the Jessie B. Cox Charitable Trust, the Boston Foundation, the Florence V. Burden Foundation, the Blue Cross/Blue Shield Foundation of Massachusetts, Partners HealthCare, and the Gardiner Howland Shaw Foundation.

References


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Join us during the ABA Annual Meeting for a free training program

**The Challenges of Working with Children as Interviewees and Witnesses**

Saturday, August 9, 2008, 2:00 p.m.—4:30 p.m., Pfizer, Inc, 235 East 42nd Street, 219 Corporate Conference Center/Lower Level, New York, NY
Preparing for the Challenges of Child Witnesses by Jill C. Engle

Free CLE credits? What’s not to like? Child advocates, family lawyers and prosecutors alike will find useful the ABA’s free webcast “Preparing for the Challenges of Child Witnesses.” First offered as a national teleconference on March 18, 2008, this online audio CLE is rich in practical tips for litigators who encounter child witnesses. The free online training is available at www.abanet.org/cle/clenow or through the Children’s Rights Litigation Committee website.

Presenters include Dr. Sherri Bourg Carter, a forensic psychologist specializing in child witnesses; Marguerite C. Gualtieri, who represents children in civil dependency and criminal abuse cases and chairs the Family Law Litigation Committee of the ABA’s Litigation Section; immigration attorney Carmen M. Chavez; juvenile division chief for the Miami-Dade Public Defender Office, Marie Osborne; the director of the National Center for the Prosecution of Violence Against Women at the American Prosecutors Research Institute, Jennifer G. Long; and Dr. Antoinette Kavanaugh, the Clinical Co-Director of the Cook County Juvenile Court Clinic and a clinical professor at Northwestern University's School of Law.

The course outlines the three stages of preparing to deal with a child witness:

- Initiating contact with the child witness
- Preparing for trial
- The child’s day in court

An overview of the main points covered in each of the three stages follows:

**Initiating contact with the child witness**

Preparation done at the beginning of your contact with the child witness is critical, whether you will be representing the child or just eliciting testimony from them as a witness. A good litigator will outline all the issues to be addressed related to the child, identify any potential issues regarding the child’s competency to testify, and consider the unique issues that arise because the witness is a child.

**Your role and relationship with the child**

Understanding two key concepts is necessary: your role in the case and your relationship with the child.

**Your role in the proceedings compared with the child’s**

Your role will be largely determined by your position, and the child’s position, as players in the litigation. Are you the prosecutor, and the child the victim? That necessitates different considerations than if you are defending a juvenile accused of a criminal act. Entirely different concerns arise when you are representing an adult in an immigration matter, and the child is a witness. Break down that immigration hypothetical one step farther and consider whether the child’s testimony is favorable to you or to the government. Stopping to clearly define your role and consider its ramifications enables you to prepare with the necessary strategy and compassion to approach the child.

Your role in the case will also dictate certain legal considerations. Those will differ depending on several factors, but mainly on whether or not the child is your client. These lines can blur easily if one is not careful. You may be tempted to advocate for the child when your role is actually to utilize them as a witness while advocating the state’s position as a prosecutor. On the other hand, if you are representing the child you must be completely clear about your role as an advocate and/or a voice for the child’s wishes. Attorney-client privilege is a helpful tool if the child is your client, but is meaningless if you interview the child purely as a witness (if, for

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Preparing for the Challenges of Child Witnesses (con’t from page 9)

example, you are the prosecutor). Your communications are not going to be confidential, and you should explain that to the child.

When considering your role, a factor easily overlooked is the impact on the child of your decision to call him or her as a witness. The child’s safety, their role in the family, and related issues cannot be ignored. You can learn much about that potential impact by simply talking to the child. Finally, whatever potential impacts loom for this child, it is prudent to make sure they have at least one advocate in the court system. If your role is something other than one of advocate for this child, you should make sure that the child has or can access an advocate. In some courts, all child witnesses and victims are assigned an advocate, but in many cases it will only happen if one or more counsel speak up and persuade the court to find the child an advocate.

Your relationship with the child

Your relationship with the child is crucial, and establishing a rapport early is key to a good relationship. You need to build a trusting relationship, but don’t expect the child’s complete trust at the outset. Give it time—ideally you will talk with the child multiple times before they ever see the courtroom.

A relationship with a child is much easier if the adult understands the child’s age and developmental level. Learn as much as you can about this child so you can determine what his or her true developmental level is. A child’s age often makes a difference in how he or she present to a judge or jury. The factfinder may have preconceived notions about kids of their age group, and you may have to compensate for those misconceptions. The child’s language skills and usage can greatly affect how they present at trial as well.

Interviewing the child

The location of your interview of the child is extremely important. You should consider whether others could overhear, and whether there would be too many distractions for the child. Something for the child to do while talking can help calm a child’s nerves, but you should avoid settings where they will see people walking by constantly or otherwise be distracted. Carefully consider who should be included in the interview. It often helps to include a parent and/or advocate when interviewing younger children. Most older adolescents, conversely, will not want anyone else present.

Use the first interview to gauge how the child might behave in court. Can they go through events chronologically? How do they respond to open-ended questions? How do they react if they don’t understand something you have asked them? How is their time orientation? Consider their overall use of language. During that first interview, don’t feel pressed to get all the necessary information. It often takes multiple meetings. Don’t underestimate the level of anxiety they’ll have, which naturally impedes communication.

Special considerations for immigration court

Remember that the federal rules of evidence do not apply within immigration proceedings. This can be beneficial to the child, because hearsay is not prohibited, and you can ask leading questions. The court will have an interpreter if language barriers necessitate it. Because credibility is a threshold issue in these cases, the child witness may be helpful in corroborating a parent’s story. Further, having other witnesses corroborate the child’s story may be key.

In asylum and refugee cases, a child’s anxiety is typically heightened, and they often are in defensive mode. Preparing them is like peeling an onion. They often have great fear of discussing their history, especially if it involved violence in their home country. If what they say could affect their parent’s removal proceeding, their anxiety is heightened. Patience and building rapport is essential in preparing these witnesses for court.

Special considerations in the delinquency context

As in immigration cases, children involved in delinquency cases often have high anxiety as well. The interview setting is often institutional (courthouses, juvenile detention centers and the like) which exacerbates it. The child’s feelings of shame contribute to their anxiety, and often cause regression as well. The stress of the delinquency setting also causes regression. Regression can affect the ability to present ideas sequentially, and to

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Lack of Education in Texas’ Alternative Education Programs (continued from page 1)

of this new form of AEP was to keep the mainstream classroom environment safe and conducive to learning. In Texas, the Safe Schools Act of 1995 ("Act") created our disciplinary alternative education programs ("DAEP") (TEX. EDUC. CODE § 37.00). The Act mandated that each school district establish a DAEP that would house students who had committed criminal violations. It also gave school districts the discretion to place students in these programs for virtually any violation of the local student code of conduct. The Act gave control to the school districts as to where they would house their DAEPs: a self-contained classroom within the school campus or in a separate facility. Additionally, the school district could choose to contract with a private provider to run their district’s DAEP.

What the Act did not do was mandate many substantive requirements of DAEPs. These programs must only provide English, math, science, history, and self-discipline. If a student needs any other class to meet graduation requirements he or she will not receive it in the DAEP. Such a dearth in educational programming may lead to a student not progressing to the next grade level, or even prevent them from graduating on time. Perhaps not surprisingly, a 2006 Texas Education Agency ("TEA") report found that DAEPs have five times the dropout rate than mainstream schools (Texas Education Agency, 2006 Comprehensive Annual Report on Texas Public Schools, available at www.tea.state.tx.us).

The Act also did not establish the minimum number of hours of instructional time for these programs. Currently, many of these programs offer less than seven hours of instruction per day – the minimum required of all other schools. Some offer as little as two. There are anecdotal reports that in some of these classrooms there are no teachers present and the students teach themselves out of modules. Also, DAEPs escape accountability for student performance because standardized test scores are attributed to the home school campus. While this decreases the incentive for schools to remove low-performing students, there is no measurement as to whether the DAEPs are assisting students’ progress in their education.

The lack of substantive requirements, as well as a lack of monitoring by TEA, has led to the implementation of poor quality DAEPs across Texas that serve as mere housing units before a student drops out of school. In Texas, over 100,000 students a year are placed in DAEPs; the numbers have consistently increased throughout the years. Several research studies have now shown that the original intent of keeping classrooms safe has become perverted and instead the majority of students sent to the DAEPs are sent for non-violent, non-criminal behavior (Texas Appleseed, Texas’ School-to-Prison Pipeline, Dropout to Incarceration: The Impact of School Discipline and Zero Tolerance, October 2007.). This places a group of non-violent students at risk of exposure to students who have been placed in the DAEP for violent conduct, and it increases a sense of disengagement from the educational process. Such disengagement is associated with an increased risk of not graduating on time or of dropping out of school altogether (American Psychological Association Zero Tolerance Task Force, Are Zero Tolerance Policies Effective in the Schools?, Adopted by APA Council of Representatives August 9, 2006.).

These school discipline practices disproportionately impact students of color as well as students with disabilities. TEA reports that statewide, at every single grade level, African-American students are overrepresented in the number of students placed in DAEPs; Latinos are overrepresented in 6th through 11th grades. For example, in Texas, while first grade, African-American students made up 14 percent of the general student population they made up 47 percent of those sent to DAEPs in the 2005-2006 school year (Texas Education Agency, 2006 Comprehensive Annual Report on Texas Public Schools, available at www.tea.state.tx.us). There is no data to support the assumption that these groups of students misbehave more than others, and research by the American Psychological Association states that African-American students may be more severely punished for less serious or subjective reasons (American Psychological Association Zero Tolerance Task Force, Are Zero Tolerance Policies Effective in the Schools?, Adopted by APA Council of Representatives August 9, 2006.)

Also, while students receiving special education account for about 12 percent of the Texas general student body population, they make up 22 percent of the DAEP

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Lack of Education in Texas’ Alternative Education Programs (continued from page 11)


Such a disproportionate application of these exclusionary school discipline practices only further marginalizes students who may already be experiencing academic difficulties.

Though the Supreme Court of the United States has held that education is not a fundamental right (SAISD v. Rodríguez, 411 U.S. 1 (1973)), they have recognized a property interest in state-compelled public education; one which requires due process protections in the event that a student will be deprived of education such as in a suspension or expulsion (Goss v. Lopez, 419 U.S. 565 (1975)). The Fifth Circuit Court of Appeals, however, considers placement in a DAEP a mere transfer not entitled to the same due process protections as a deprivation of education (Nevares v. San Marcos ISD, 620 F.2d 493 (5th Cir. 1980)). In Texas, school districts have the discretion to provide an appeal process to such a placement; it is not mandated. The only requirement to comply with due process is that the school must hold an informal conference with the parent and the student before the student is placed in the DAEP.

The Fifth Circuit decision has made it difficult to challenge these DAEP placements through litigation. Instead during the 80th Texas Legislative Session, in January 2007, advocacy groups turned to the legislative process to address this issue. Nearly 13 years after the inception of DAEPs, in answer to these groups’ efforts, legislation passed requiring TEA to establish minimum standards for DAEPs (HB 426, 80th Texas Legislature). The standards TEA has currently proposed include the following:

1. One teacher for every 15 students;
2. A full, seven-hour school day;
3. Comprehensive developmental guidance and counseling;
4. Annual training for DAEP staff; and
5. Transition services from the sending school to the DAEP and back to the sending school.

Before the Texas Legislature mandated that TEA draft the minimum standards, TEA researched best practices in DAEPs (Texas Education Agency, Disciplinary Alternative Education Program Practices, August 2007). Many of the standards they have drafted comport with this research. TEA solicited public comments on the proposed standards in the months of February and March 2007. Some school organizations expressed concern that these proposed standards will be difficult and costly to implement, especially the teacher-student ratio. A conversation with a representative from TEA revealed that the commentators were concerned that the proposed minimum standards are all unfunded mandates. One can empathize with the schools’ concerns, many of our school districts are already financially strapped, but, the school districts and the Texas Legislature must come together to ensure that: (1) school districts do not abuse their discretionary authority in placing a student in a DAEP and (2) once the student is placed in the DAEP the student can continue to progress in his or her educational attainment.

To be sure, schools have a duty to maintain discipline and order to ensure a safe environment and promote learning. The contradiction is that the discipline practices through which some schools attempt to achieve these goals ultimately funnel students out of our schools and place them at risk of future involvement with the criminal justice system. As noted earlier, DAEPs have a significantly higher rate of student dropouts and research correlates dropping out of high school with an increased risk of involvement with the criminal justice system. In Texas, more than 81% of the prison population has dropped out of school (Texas Comptroller of Public Accounts, 2006 Fiscal Notes, December 2006). This has become what many advocates have coined the “school-to-prison pipeline.” This country has a strong social and economic interest in continuing to educationally serve suspended or expelled students. To that end, the AEP must be more than mere a stop along the pipeline.

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Preparing for the Challenges of Child Witnesses (continued from page 10)

understand questions from you, the judge and the other attorneys. Plus, these kids often mistrust authority, have defeatist attitudes, and bear a history of abuse or neglect. It takes a lot of interviews to overcome these barriers.

Acquiring the child’s records from school, medical providers and social workers and getting the key information from those reports to the judge can help frame the child’s story and lessen the impact of the barriers described here. You should strive to answer three questions: 1) who is this child? 2) why did he get here? and 3) how can we best intervene now that he is here?

Competency to testify

In most states, all witnesses, including child witnesses, are presumed competent to testify until a party challenges their competency. Age alone is usually not determinative of incompetency, but age coupled with other compelling reasons can sometimes persuade a judge. Thus, you need to decide if it is prudent for you to raise the issue. If you do, the court will normally consider several factors, including the child’s ability to observe, recall and communicate information, their understanding of the difference between the truth and a lie, and whether they understand the oath.

How can you determine what your child witness can understand regarding this issue? Back to those critical interviewing skills. Ask the right questions. Test the child’s descriptions of past events against others’ descriptions of same. Get down to their level on the truth vs. lie issue: “if you told your teacher that something bad happened to you but it didn’t really happen, you were just making it up, would that be the truth or a lie?” Avoid questions with extreme facts, such as “if I said my hair is purple, is that the truth or a lie?”

Preparing for trial

As all good litigators know, you must simultaneously prepare for this opportunity to educate the court, the jury, and the other parties, about the merits of your case. What makes preparation for a child witness unique is the threshold question that should always come first: what are the potential ramifications of the child’s testimony? You should honestly explore whether or not the child is adequately supported to deal with all the potential repercussions.

Next, assess the forum (civil, criminal or family court), which will determine factors such as the burden of proof, applicable laws and evidentiary/procedural rule. Consider motions in limine, which can educate the court on developmental and factual issues; or help reduce stress on the child by separating him from the defendant. In your filings, tell the child’s story, supplemented with expert opinions that provide objective corroboration of that story. Expert witnesses may help educate the court about child witness issues such as delayed disclosures and recantation. Decide what evidence you have that helps tell the child’s story, to minimize the stress of the child having to articulate every detail. If pretrial meetings are held with the judge, consider requesting a closed courtroom and/or other accommodations to make the courtroom less threatening for the child.

Finally, tell the child what to expect. Explain the roles of the different people in the courtroom. Reviewing testimony with the child helps build your rapport. Be patient and reassuring, and above all listen to their story. By reviewing the child’s story, you are actually going through your direct exam.

Practice cross examination. Tell them to speak up if they don’t understand a question. Let them sketch out or act out their facts if they are more comfortable that way. Check back with the child periodically before trial. She may disclose facts piecemeal, and if they are pivotal facts, amend your filings accordingly.

The child’s day in court

With adequate preparation, the actual day in court will go smoothly. Still, several unique approaches apply when children are testifying. Do not hesitate to request accommodations, e.g., smaller witness chairs or the judge taking off his or her robe, based on what is allowed in your jurisdiction. If possible, separate the child from any individuals they are afraid of. Orient the child in advance by touring the courtroom prior to trial. Testimonial aids that can be used in court include dolls or puppets, drawings or diagrams, and photographs. As mentioned above, it may also help to have the child “act out” what happened.

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Preparing for the Challenges of Child Witnesses (continued from page 13)

One should consider several issues related to the language used in court. Don’t assume that the child can understand all the language. Many children, particularly older adolescents, assume they will understand everything because they expect it to be like what they see on TV. The problem comes when they get into court and are too embarrassed to admit that they don’t understand. Therefore, it helps to remind them that it is acceptable to ask for clarification. Furthermore, it is often necessary to educate the court about the importance of using open ended questions with kids. Your job is to fill in the gaps for the fact-finder. Finally, be aware that the hearsay restrictions may be looser on child witnesses, due to local rules or practices.

The preparation of and for child witnesses is best done well in advance of trial and should involve an investment of considerable time and energy on the attorney’s part. Take advantage of this free online resource and beef up your skills on this significant issue, which is often ignored by practitioners and judges alike. As one panelist stated, “children are not small adults.” They deserve our specialized attention when they are facing the daunting process of a trial. The online training offered on the ABA’s CLE Now! Website is invaluable for anybody facing this process, whether it is a small or large part of their practice. The seminar runs just under 85 minutes and is completely free of charge.

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Chair’s Column (continued from page 2)

Volunteers bring a “fresh” perspective to desperately overburdened systems of children’s justice

Child welfare case workers have responsibility for an unreasonably and often irresponsibly high number of children. Juvenile court judges have too many matters set for trial, disposition, hearing or even just status on any given day, week or month. Defenders are overburdened with caseloads that often prevent them from completely working up a case in a delinquency setting. Children’s clinics with limited staff and resources often have to turn away valid claims of children with immigration cases, public benefits matters, or civil claims because their staffing and resources have simply become overwhelmed by the great need for this advocacy. In a maxed-out system like this, sometimes it is the lone volunteer attorney coming in with their one pro bono case that can cause the system’s actors to stop a moment to take a look at the system to which they are contributing. Sometimes one voice can help all the stakeholders re-examine and remember the importance of the work that they are doing everyday and help them consider new, more creative ways of addressing these problems. Volunteer attorneys with even one case can be a conduit for change.

Representing a child means helping and strengthening a family

A child is obviously just one member of a family. When a child is facing legal problems it is not just that child’s challenge. Whether it is a lack of public benefits, failure to receive services in school for disability, or citation in the criminal or municipal system for a serious or even minor offense; it disrupts a family. Assisting that child in navigating their access to justice can help a burdened family overcome a situation that might otherwise have had a devastating effect on their success as a family.

Children are not just “little adults” – they need specialized care

Often children have legal needs which, at first glance, appear to be exactly the kinds of needs that adult clients have for pro bono advocacy. A closer
There are a variety of areas of law where advocacy is needed

Unaccompanied children cross our borders every day often fleeing torture and abuse. Children are arrested and detained in juvenile jails every day for offenses ranging from truancy to felonies. Children are the victims of divorces, domestic violence and custody disputes in every county in the nation. Children are denied benefits they rightfully deserve. Children are unduly suspended, expelled or denied disability services from schools in many towns and cities. So many areas of law beg for creative thinking, more resources and the finest lawyers. This is where a volunteer lawyer’s best efforts are truly needed.

You are essential.

One visit to a children’s court. One discussion with a detained child. One meeting with a school official. Any of these experiences would convince even the least interested attorney that children’s advocacy is desperate for champions. Children’s cases require sharp thinkers, committed advocates, zealous representation and the highest level thinking on these complicated issues facing poor and disadvantaged children. To find out more about volunteering for children, visit our website at http://www.abanet.org/litigation/committees/childrights/ or contact our committee director, Catherine Krebs at (202) 547 3060 or krebsc@staff.abanet.org •

Angela Vigil is the North American Director of Pro Bono and Public Service for Baker & McKenzie LLP. Her full-time pro bono practice includes representation of children in juvenile justice, appeals, family law, education law and various civil matters.

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The Attorney-Client Privilege and the Work-Product Doctrine
Fifth Edition
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The Attorney-Client Privilege and the Work-Product Doctrine has helped thousands of lawyers through this increasingly complex area. In addition to providing a comprehensive overview of the current law of the attorney-client and work-product immunities, this perennial ABA best-seller includes case illustrations and contextual examples, as well as numerous tips and guidance. Practical, accurate, reliable and clear, this book is the ideal guide for a practicing litigator: intellectually rigorous, but without the theoretical and academic baggage that can make writing on this subject cumbersome and leaden. The Fifth Edition maintains the style and emphasis of the previous editions, but now is divided into two volumes. Volume One examines the attorney-client privilege and Volume Two covers work-product protection and factors common to both the attorney-client privilege and the work-product protection.

2007, 2 VOLUMES (1,474 PAGES), 6 X 9, PAPER
ISBN: 978-1-59031-804-1
PC: 5310363
$195.00 Regular price
$165.00 Litigation member price
1-800-285-2221 www.ababooks.org