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20 Years of Advocating for LGBTQ Youth in Out-of-Home Care

By M. Currey Cook and Cathren Cohen – April 17, 2018

Government-funded systems for youth in out-of-home care have laudable and important public policy goals. The juvenile justice system is designed to rehabilitate youth; child welfare is designed to ensure a safe, permanent home; and runaway and homeless youth systems are designed to provide secure, temporary shelter and helpful services. Some youth in care, however, have always been unofficial exceptions, left by the wayside with their needs unmet and system promises to serve all youth, regardless of who they are, unfulfilled. Lesbian, gay, bisexual, transgender, and queer or questioning (LGBTQ) youth have long been one of these exceptions. Thankfully, over the past 20 years, change has come for many of these youth in the broader world and in out-of-home care, but full inclusion in the promise of care and assistance still eludes far too many.

System Involvement of LGBTQ Youth

Simultaneously invisible to many and targeted by others, LGBTQ youth often end up in out-of-home care systems that, in reality, serve as catchment areas for the most marginalized children in our society. For LGBTQ youth who are youth of color, undocumented immigrants, from low income families, living with disabilities, or at the intersection of many or all of these identities, inequities and discrimination in society and in care are greater still. LGBTQ youth are disproportionately represented in out-of-home care systems. Despite making up only an estimated 5–7 percent of the general population of young people, youth who identify as LGBTQ account for almost 25 percent of youth in foster care, 20 percent of youth in the juvenile justice system, and nearly 50 percent of youth experiencing homelessness, according to an April 2017 study, Safe Havens (discussed below). Once in care, these youth are more likely to face victimization, harassment, discrimination, more placement moves, and placement in group homes, psychiatric treatment centers, and detention settings. In the world at large, due to societal prejudice, LGBTQ youth are at higher risk for physical and emotional victimization, trafficking, and negative health outcomes, including self-harm and suicide. Discrimination and mistreatment while in government care only increases this risk factors and exacerbates poor public health outcomes.

Family rejection is frequently a factor leading to multi-systemic involvement. Being kicked out or pushed out by family often forces youth out of their homes, either into foster care or homelessness. Discrimination and bullying in schools cause many LGBTQ youth to feel unsafe, and many skip class, increasing their risk of becoming involved in the system. Some youth
experiencing homelessness are driven to participate in street economies, including sex work, to meet their survival needs. LGBTQ youth in general, and LGBTQ youth of color in particular, are more likely than their heterosexual and cisgender peers to be stopped or arrested by law enforcement and to be detained. Juvenile involvement and homelessness often have an impact on youth for the rest of their lives, causing barriers to housing, education, and employment.

**Progress and Some Setbacks**

Despite the prevalence and experiences of LGBTQ youth in out-of-home care, the specific needs of LGBTQ youth have not been adequately addressed; as a result, systems themselves have been complicit in causing additional trauma and poor outcomes. Thankfully, the last 20 years have shown a slow but steady increasing recognition by professionals that their work necessarily involves working with LGBTQ youth and requires improvements in policy and practice. Some states have enacted specific laws protecting LGBTQ youth from discrimination and mandating supportive treatment. However, other states have taken harmful steps backwards, enacting "religious refusal" laws that permit child welfare providers to discriminate against LGBTQ youth based on their religious or moral beliefs (See Child Welfare (map)). This article highlights the great strides that have been made to protect LGBTQ young people over the past few decades and points out areas where additional reform is necessary to protect LGBTQ young people and the adults they grow up to be.

When Lambda Legal's Youth in Out-of-Home Care Project was founded in the 1990s, it was focused exclusively on LGBTQ youth in foster care. In 2001, Lambda published *Youth in the Margins: A Report on the Unmet Needs of Lesbian, Gay, Bisexual, and Transgender Adolescents in Foster Care*, a groundbreaking survey of 14 states' policies and practices. The report found that, unsurprisingly, LGBTQ youth were often neglected and marginalized by state child welfare systems. *Youth in the Margins* also demonstrated the need for best practice guidelines for well-meaning but uninformed child welfare professionals. In subsequent years, this gap has been filled in with a plethora of important recommended practices and a body of professional standards.

**A Multidisciplinary Approach: Best Practices**

The movement for rights of LGBTQ youth in court and systems of care has been bolstered over the past 20 years by recognition by other professional children's rights organizations. While organizations that advocate specifically for LGBTQ youth are important, statements of support by mainstream child welfare groups bring best practice recommendations to a wider audience, including people who may be more responsive than if the recommendations were to come from an LGBTQ-specific organization.

In 2002, the Model Standards Project was launched as a joint project of Legal Services for Children and the National Center for Lesbian Rights. The goal of the project was to give child
welfare and juvenile justice agencies accurate and up-to-date information on best practices for providing services to LGBTQ youth. In 2006, the project partnered with the Child Welfare League of America (CWLA) to publish the first ever set of comprehensive guidelines for professionals working in child welfare and juvenile justice systems to best serve LGBT youth: CWLA Best Practices Guidelines: Serving LGBT Youth in Out-of-Home Care. The 2006 CWLA Best Practices Guidelines gave information to providers about creating an inclusive culture, supporting family acceptance and reconciliation, focusing on permanence, and promoting positive development and expression of sexual orientation and gender identity. The guidelines also provided concrete recommendations for the placement of LGBT youth and the provision of health and mental health services to them.

While the CWLA Best Practices Guidelines was the first report of its kind, many more came in its wake. Also in 2006, CWLA and Lambda Legal coordinated to release two reports: Out of the Margins: A Report on Regional Listening Forums Highlighting the Experiences of Lesbian, Gay, Bisexual, Transgender, and Questioning Youth in Care and Getting Down to Basics: Tools to Support LGBTQ Youth in Care. In 2012, CWLA’s published Recommended Practices to Promote the Safety and Well-Being of Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) Youth and Youth at Risk of or Living with HIV in Child Welfare Settings. Recommended Practices was groundbreaking because it included a call from leading child welfare organizations to support LGBTQ youth in care. CWLA worked with a national group of 13 institutional coauthors to consolidate and summarize the work of leaders in medicine, law, and social sciences:

- The Child Welfare League of America
- The American Bar Association Center on Children and the Law: Opening Doors for LGBTQ Youth in Foster Care Project
- Diane E. Elze
- The Family Acceptance Project
- Lambda Legal
- Legal Services for Children
- Gerald P. Mallon
- Robin McHaelen
- The National Alliance to End Homelessness
- The National Center for Lesbian Rights
- The National Center for Transgender Equality
- The National Network for Youth
- The Sylvia Rivera Law Project

The report also included statements of support for LGBTQ youth by the National Association of Social Workers, the American Psychological Association, the American Academy of Pediatrics, and the American Academy of Child and Adolescent Psychiatry, and called for providers to
adopt and implement written nondiscrimination policies to protect against discrimination on account of sexual orientation and gender identity and HIV status; to provide mandatory LGBTQ competency training to all employees, volunteers, and foster and adoptive parents; and to specifically support transgender and gender-nonconforming youth by affirming their identity and expression.

**Youth-Affirming Litigation Efforts**

In the past 20 years, the rights of youth have also been supported through successful federal and state litigation efforts. Perhaps the most notable case is *R.G. v. Koller*, the first and only case in which a federal court has heard and affirmed the right of LGBTQ youth to be free from harassment and discrimination in the juvenile justice system. In 2005, the American Civil Liberties Union (ACLU) filed suit against the Hawaii Youth Correctional Facility (HYCF), a state juvenile justice facility, on behalf of three young people. The plaintiffs were between the ages of 17 and 18 and were residents of HYCF who identified as, or were perceived as, LGBTQ. The suit alleged that staff and officials of the Hawaii Department of Human Services routinely ignored and sometimes actively participated in a culture of harassment and violence against LGBTQ youth in its care.

Among the allegations by the youth represented by the ACLU were verbal harassment by guards against LGBTQ residents, including inciting similar harassment by other residents; reprimands that included telling LGBTQ youth that they were bound for hell; housing LGBTQ youth in solitary confinement as a means of their "protection"; and refusal by staff to intervene when LGBTQ youth experienced sexual harassment or assault by other youth. After a preliminary finding that the youths' constitutional rights were likely violated, HYCF settled the case in 2006 on the condition that it would cease harassment of LGBTQ youth and implement relevant reforms. In one of the earliest victories of its kind for LGBTQ youth in the juvenile justice system, the settlement included a requirement that the facility develop and implement an antidiscrimination policy specifically to uphold the rights of LGBTQ youth in its care.

In *L.P. v. Philadelphia, et al.*, the City of Philadelphia was required to provide medical treatment for a transgender young person living in a secure youth facility. In 2011, Lambda Legal settled a discrimination complaint it had filed against the city's Department of Human Services and affiliated entities on behalf of L.P., a transgender girl who suffered discrimination and abuse while in the custody of the city's Youth Study Center (YSC), a secure, short-term youth detention facility. In the year and a half that L.P. spent in the care of the YSC, staff consistently refused to respect her gender identity. She was housed in a male unit and refused affirming services, including gender-affirming medical care, and clothing and grooming options in accordance with her identity. In addition, she endured verbal abuse from staff and physical attacks by other residents, while staff failed to either protect her or appropriately punish her assailants and failed to call her by the name and pronouns she used. A settlement of the
complaint included revisions to YSC policies addressing nondiscriminatory treatment of LGBT youth to include specific protections for transgender youth. These revisions included access to gender-affirming housing, clothing, and grooming options; the use of a transgender youth's personal name and pronoun; provision of necessary medical care; and required training for all staff regarding respectful communication and policy requirements.

In New York City, the case of Mariah L. v. Administration for Children's Services affirmed that transgender youth in foster care must be provided access to affirming medical treatment. Mariah L. was a transgender girl who had been in the care of New York City's Administration for Children's Services (ACS) since she was 10 years old. When she was 18, multiple health care providers determined that necessary therapeutic treatment for Mariah's gender dysphoria included gender-confirming surgery. However, although ACS was legally required to pay for medical care for children under its jurisdiction, the agency refused to cover the cost of Mariah's surgery on the grounds that it was "experimental" and "not medically necessary." The Legal Aid Society represented Mariah in New York City Family Court, where she obtained an order requiring ACS to provide the necessary treatment. ACS filed an appeal. In 2006, the Appellate Division remanded the case to family court, demanding that ACS provide a clear reason for its denial of treatment to Mariah.

A similar outcome occurred in Matter of D.F. v. Gladys Carrion, another case brought by NYC's Legal Aid Society. In 2014, D.F. was a 20-year-old transgender woman who had been in the care of New York City's ACS for five years. Part of the impetus for the removal of D.F. from her parents' home was their refusal to accept her sexual orientation or gender expression, resulting in their verbal and physical abuse of her. During her time in care, D.F. came out as transgender and legally changed her name and gender marker to reflect her female identity. She began undergoing hormone therapy, as reflected in her ACS case plan. However, when D.F. sought to undergo further procedures that would align her physical body with her gender identity, ACS refused to cover the medical costs, in violation of its own policy. ACS cited D.F.'s frequent absences from her care facilities as reason to refuse to finance the procedures, claiming that it could not be certain that D.F. would comply with necessary follow-up protocol. The court found ACS's decision to be "arbitrary and capricious" and ordered the agency to cover the cost of all further procedures that had been requested by D.F. to treat her gender dysphoria.

LGBTQ Nondiscrimination Laws—and Discriminatory "Conscience Clause" Laws
Advocacy and child welfare organizations have been successful in protecting the rights of LGBTQ youth by passing some state and local nondiscrimination laws and agency policies. In 2017, Lambda Legal, Children's Rights, and the Center for the Study of Social Policy published the first report to detail the laws and policies to protect LGBTQ youth in child welfare, juvenile justice, and homelessness systems of care in all 50 states, entitled Safe Havens: Closing the Gap Between Recommended Practice and Reality for Transgender and Gender-Expansive Youth in
Out-of-Home Care. When Safe Havens was published, it reported that only 27 states and the District of Columbia have nondiscrimination protections in the child welfare system for sexual orientation and gender identity and that only 21 states and the District of Columbia have such laws in the juvenile justice context. The report also highlighted the lack of protections for homeless youth; only 12 states and the District of Columbia have policies applying to facilities serving runaway and homeless youth that protect against discrimination on the basis of sexual orientation and gender identity and expression (SOGIE).

The state-by-state information collected in writing the Safe Havens report was organized into two maps, one for child welfare systems and one for juvenile justice. The dynamic maps indicate whether each state has a child welfare- or juvenile justice-specific nondiscrimination statute, regulation, or agency policy on the books and, if so, whether it protects against discrimination based on sex or gender only, sexual orientation and sex or gender only, or sexual orientation and gender identity, or if the state has a statewide LGBTQ-specific agency policy. These maps have provided Lambda Legal and allies with valuable information on gaps in protection across the country.

Another critical and growing legislative trend, led by NCLR’s #bornperfect campaign and national and local allies across the country, is to protect LGBTQ youth from so-called "conversion therapy," or therapy aimed at changing or suppressing LGBTQ identity in children. The practice is harmful to youth and condemned by all credible medical, social science, and child welfare organizations. However, currently only ten states (California, Connecticut, Illinois, Nevada, New Jersey, New Mexico, Oregon, Vermont, Rhode Island, and Washington) and Washington, D.C., prohibit the practice.

On a concerning note, increasing numbers of states have passed religious refusal laws in the context of child welfare. Currently, Alabama, Michigan, Mississippi, North Dakota, South Dakota, Texas, and Virginia have laws that prohibit states from taking any adverse action against child welfare providers (or child placement agencies) for actions that they take because of their religious or moral beliefs. Under such laws, providers can decline to allow same-sex couples, unmarried couples, or individuals of different faiths than their own from fostering or adopting children. Texas's law specifically allows providers to impose their religious beliefs and practices on the children in their care, which alarmingly opens LGBTQ youth to dangerous "conversion therapy" practices.

Lambda Legal is involved in a wide-reaching coalition dedicated to fighting against the proliferation of child welfare religious refusal laws. LGBTQ, child welfare, and civil rights organizations have banded together to oppose efforts to introduce new legislation that would expand discrimination to other states. The Every Child Deserves a Family Coalition is both working to oppose state laws and working affirmatively to develop affirming child welfare
systems through grass roots efforts and by passing nondiscrimination laws on the state and federal levels.

In addition to policy advocacy, litigation efforts are under way to challenge discriminatory practices in provision of government funded care to children. The ACLU is also challenging Michigan’s child welfare religious refusal law in *Dumont v. Lyon*. The ACLU sued on behalf of two same-sex couples who were turned away by state-contracted child placement agencies under the Michigan conscience clause law. The complaint alleges that the law violates the Establishment Clause and equal protection principles. Similarly, Lambda Legal, in *Marouf v. Azar*, is suing the U.S. Department of Health and Human Services and the U.S. Conference of Catholic Bishops on behalf of a lesbian couple in Texas who were denied an opportunity to foster a refugee child. Catholic Charities Ft. Worth, a federally funded provider for refugee children and unaccompanied minors, turned the couple away because they did not "mirror the Holy Family." Lambda filed suit, alleging that the organization's actions violate the Establishment Clause, equal protection, and substantive due process.

**Looking Forward to the Next 20 Years**

While LGBTQ youth in care enjoy greater protection of their rights today than they did 20 years ago, there is still a long way to go. Advocates will need to continue to fight discriminatory laws that seek to demonize transgender people or use religions as a reason to discriminate, while simultaneously working to pass nondiscrimination laws and promulgate affirming policies in states where they do not yet exist.

In addition, to fully protect system-involved LGBTQ youth, more must be done to protect youth experiencing homelessness. While federally funded programs and services must now protect LGBTQ youth, at the state level protections are not comprehensive and many youth must rely on unsafe and non-affirming shelters. New York State offers a promising model. In 2015, the state amended its law regulating programs that provide services to runaway and homeless youth to include an explicit statement that program staff and volunteers may not "engage in or condone discrimination or harassment on the basis of . . . sex, sexual orientation, gender identity or expression." *N.Y. Comp. Codes R. & Regs. tit. 9, § 182-1.5(g)(i).*

As protections and support have increased, so have the number of LGBTQ youth who are able to share their lived experiences in care—both negative and positive—and help shape policy and practice reform for the better. Youth in Florida, Nevada, Texas, Virginia, and many other places around the country are actively involved in making change. Our communities must help ensure that they are not only supported but compensated for their time as the valued consultants they are. Grassroots organizations social justice organizations led by queer and trans youth of color like BreakOUT in New Orleans and Advocates for Richmond Youth and LGBTQ-specific community support centers and transitional housing programs such as Zebra Coalition in
Orlando, Diversity House in Baton Rouge, Ruth Ellis Center in Detroit and Sanctuary in Palm Springs, are invaluable resources that have been critical players in systemic reform in their communities and provide youth the support to play a critical role in improving the experience of their peers both now and in the future.

Finally, new issues facing LGBTQ youth have become more apparent in recent years, creating new challenges and areas of work for advocates. One area of recent advocacy is around sex offender laws, which disproportionately affect LGBTQ young people. According to a 2016 report, *Unjust: How the Broken Criminal Justice System Fails LGBT People*, young people who have relationships with people of their same sex are at risk for criminalization because their sexual behavior is considered less acceptable by family members, school officials, and police. In addition, Romeo and Juliet laws—which lessen or decriminalize statutory rape crimes when the individuals are less than a few years apart in age—sometimes contain gendered language, meaning that LGBTQ young people are subject to serious criminal penalties for consensual sexual activity. When these young people are required to register as sex offenders, it affects their ability to access education, housing, employment, and welfare for the rest of their lives.

New social science research demonstrates the harm to youth of being subjected to sex offender registration laws. First, children who commit sexual offenses have a very low risk of reoffending [registration required], as much as eight times lower than the rate of general recidivism by youth. In addition, research has shown that registered children have negative health outcomes—compared with non-registered children, children required to be on the register have higher rates of attempted suicide, problems with peers, and unwanted sexual conduct and sexual assault. They also report less safety and more experiences with violence. These studies demonstrate the importance of continued challenges to the constitutionality of such laws and provide a means to do so. The primary authors of the two studies described above—Dr. Michael Caldwell and Dr. Elizabeth Letourneau—have served as experts or submitted affidavits in support of two successful challenges to juvenile sex offender registration schemes. These challenges are especially important for LGBTQ youth because they already face public health disparities and discrimination in housing and employment.

**Conclusion**

It's past time to end these disparities and ensure that civil rights of youth in care are not an afterthought but a core aspect of ensuring their well-being. Most importantly, going forward we must support and elevate the brave youth who are making change every day by refusing to be anyone but themselves and we must allow them to lead the way to true equity.

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It has been 20 years since the formation of the Children's Rights Committee. And in that 20 years, a lot has changed in advocacy for children in the United States. To celebrate our committee's anniversary, there will be in-depth articles focusing on different areas of law that have had major impacts on children as well as the capstone event Children's Rights are Human Rights, scheduled for May 1, 2018, at the University of San Diego Joan B. Kroc Institute for Peace & Justice.

This article focuses on just a few of the major reforms and legislation from about 20 years ago, reviews the proposed impact, and evaluates whether the proposed impact and actual impact aligned. Our society's view of juveniles has certainly changed, but it is helpful to take a critical look at whether we are on the right path in effectuating positive changes and advocacy for one of our most vulnerable populations.

Welfare Reform Act of 1996

In 1996, President Bill Clinton signed into law the Personal Responsibility and Work Opportunity Act (PRWOA), which came to be known as the biggest welfare reform law since the New Deal by President Franklin Roosevelt in the 1930s. The bill created Temporary Assistance for Needy Families (TANF), which replaced the Aid to Families with Dependent Children (AFDC), a program that had been in place since 1935. (Kathryn Edin & H. Luke Shaefer, "20 Years Since Welfare Reform," Atlantic, Aug. 22, 2016.)

The federal funding came in the form of block grants to the states, which gave states more flexibility to determine their own program, so long as it conformed with basic federal requirements. The requirements set forth by TANF placed time limits on eligibility for recipients. Recipients were required to begin working after two years, and there was a lifetime limit on receipt of federal funds after five years. TANF allowed states to enhance enforcement of child support. The federal restrictions limited funding for immigrants until they were in the United States for five years; however, states could use their own funds for immigrant families. There was also a lifetime ban on food stamps for convicted drug felons; however, states were able to opt out of this plan. As of 2014, 40 states had opted out.

One of the main goals of TANF was to reduce the caseloads of AFDC recipients. Conservatives believed that the United States had become a welfare society, and so they were determined to
end welfare fraud and the welfare state. The thought process was that if someone continued to receive cash assistance in perpetuity, then that individual would abandon all motivation to return to work. Encapsulated by President Reagan's reported story of a "welfare queen" who lived in Chicago's South Side, the perception was perpetuated and helped fuel this massive legislative reform.

**Impact of the welfare reform act of 1996.** Because the states received the federal funding via block grants, the amount of the grant decreased with inflation, which in effect causes the grant to disappear over time. (Vann R. Newkirk II, "The Real Lessons from Bill Clinton's Welfare Reform," *Atlantic*, Feb. 5, 2018.) The state was given flexibility to use the funds to fill holes in some of the programs offered by the state, which, in turn, decreased the amount of funding for actual cash assistance and child care funding—two of the core components of the AFDC, now TANF. (See *id.*

TANF also had other incentives to reduce the number of people receiving the funds. Problematically, the reforms created a false equivalency between restricting access to welfare under TANF's stricter requirements and actually lifting people out of poverty. A recent study from the Center on Budget and Policy Priorities, *TANF Reaching Few Poor Families* (2017), shows that TANF provides cash assistance to only 23 percent of all families who live in poverty. By contrast, at its height, the AFDC program provided cash assistance to about 75 percent of poor families. (See "The Real Lessons," *supra.*) In addition, the number of people receiving benefits has not correlated with a decrease in the number of people in poverty.

In fact, the results of the reform are pretty grim. In 2012, according to government data, roughly 3 million children in the United States live on no money for three months a year. (See "20 Years Since Welfare 'Reform'," *supra.*) As of 2014, there were only 850,000 parents with 2.5 million children receiving TANF, which represents a decline of 75 percent from the AFDC. (See *id.*) Even though the number of caseloads of families on TANF decreased, the number of families with children in poverty increased by 17 percent between 1995 and 2010, from 6.2 million to 7.3 million, and the number of children in poverty climbed by 12 percent, or by 1.7 million children. (LaDonna Pavetti & Danilo Trisi, *TANF Weakening as a Safety Net for Poor Families* (Ctr. on Budget & Policy Priorities Mar. 14, 2012).) While the reform was designed to improve self-sufficiency and move individuals from welfare assistance into steady and stable employment, it has merely forced people off of assistance without providing enough time or adequate assistance in helping poor families achieve stability.

**State Children's Health Insurance Program of 1997**

In 1997, 10 million children in the United States did not have health insurance coverage. Many
of these children were part of the "working poor" families whose incomes were just high
eough to deem them ineligible for Medicaid benefits. After President Clinton's failed attempt
to reform health care in 1993, congressional leaders and the administration recognized the
need for incremental changes to health care, focusing first on covering children. The bipartisan
support for expanding children's health insurance culminated in the passage of the Children's
Health Insurance Program (CHIP) as part of the Balanced Budget Act of 1997. (See Medicaid &
CHIP Payment & Access Comm'n (MACPAC), History and Impact of CHIP.)

CHIP was the largest taxpayer-funded expansion of health insurance coverage for children since
President Johnson established Medicaid in 1965. It provides federal matching funds to states to
expand health insurance programs for children in families whose income is too high to qualify
for Medicaid but too low to purchase individual health insurance. (See Medicaid.gov, Program
History.) The idea was to serve families whose income is up to 200 percent of the federal
poverty guidelines.

Some of the distinctions from Medicaid were that states had more flexibility in creating their
own program and that there was enhanced federal funding. States could use the funds in one
of three ways: (1) to create a separate child health insurance program from Medicaid, (2) to
expand their Medicaid program, or (3) to design a program that combines options 1 and 2. By
2000, all 50 states and the District of Columbia were participating in CHIP and had children
enrolled in the program. (See History and Impact of CHIP, supra.)

Impact of CHIP coverage. The Henry J. Kaiser Family Foundation published a report on
July 17, 2014, finding that from the enactment of CHIP in 1997 through 2012, the
uninsured rate of children fell by half, from 14 percent to 7 percent. (Julia
Paradise, "The Impact of the Children's Health Insurance Program (CHIP): What Does
the Research Tell Us?" Henry J. Kaiser Family Found., July 14, 2014.) By 2016, the
number of uninsured children was around 3.8 million, as opposed to the 10 million
uninsured children when CHIP was passed. (See History and Impact of CHIP, supra.) The
Kaiser Family Foundation found that children with Medicaid and CHIP have much better
access to primary and preventive care, fewer unmet needs, and increased access to
specialists and dental care, though some research suggests that those receiving
Medicaid and CHIP coverage have a harder time finding specialists and dental care.

Both Medicaid and CHIP have helped to reduce disparities in coverage affecting both
low-income children and children of color. In addition, there is evidence that improved
health of children with Medicaid and CHIP coverage also means educational gains that
impact economic well-being and productivity. (See The Impact of the Children's Health
Insurance Program (CHIP), supra.)

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CHIP was reauthorized in 2009, and the Patient Protection and Affordable Care Act of 2010 strengthened provisions of the existing program and extended funding until September 2015. (Georgetown Univ. Health Policy Inst.: Ctr. for Children & Families, The Children's Health Insurance Program (Feb. 6, 2017).) The Reauthorization Act of 2009 allowed states to expand coverage to pregnant women, which 20 states now offer. (See id.) In January 2018, Congress extended CHIP funding for an additional six years, and in February, funding was extended for an additional four years with the passage of the Bipartisan Budget Act of 2018, thus ensuring CHIP funding until 2027.

No Child Left Behind Act of 2001
There had been growing concern that American children were not receiving the education necessary to allow them to compete on the international playing field. (Alyson Klein, "No Child Left Behind: An Overview," Educ. Wk., Apr. 10, 2015.) Congress enacted NCLB in 2001, which was signed by President George W. Bush in January 2002. The bill called for major reforms in public schools, and if schools chose not to implement the reforms, they risked losing their federal funding. (See id.) One of the most visible pieces of this legislation was the annual standardized testing schools were required to do. Students in third through eighth grades were to be tested in math and reading on an annual basis, and testing was to occur once in high school. Schools and teachers were evaluated on the basis of the scores achieved on these tests. (See id.)

States were left to create their own tests based on what they considered to be "proficiency" in reading and math. States had to bring all students to the proficient level by the 2013–2014 academic year. They also had to report the scores of the yearly standardized testing, breaking down the statistics for the whole school population into different subgroups, including students who were English-language learners, students who were receiving special education, and non-Caucasian students.

If schools failed to meet the state standards, they would face harsh consequences. Specifically, the schools were required to track their "adequate yearly progress" (AYP) toward the proficiency goals. If schools did not meet their AYP for two years in a row, they could be sanctioned. Sanctions were graduated depending on how many years in a row the school did not meet AYP and included allowing students to transfer to other schools in the same school district, providing free tutoring, or having the state take over the school, which could include having federal funds withheld and providing school vouchers. (See id.)

Another major component was that schools were required to ensure that teachers were "highly qualified," which generally meant a bachelor's degree in the area in which they teach in addition to state certification. (See id.) Another aspect of the law required school districts to
inform parents annually of their students' performance and scores in school. (New America, NCLB.)

**Impact of NCLB.** One success of NCLB is that its requirement that schools release information about the different subgroups and their test scores helped identify where education gaps existed and helped demonstrate the need to better assist the subgroups overall. (Tamar Lewin & Motoko Rich, "No Child Left Behind Law Faces Its Own Reckoning," *N.Y. Times*, Mar. 20, 2015.) However, since its enactment, there were many problems quickly identified by schools, parents, educators, and politicians. Even Arne Duncan, education secretary during NCLB, is quoted as saying in 2015 that the law "created dozens of ways for schools to fail and very few ways to help them succeed or reward them for success." (See id.) The 2013–2014 deadline for schools to reach proficiency was set out in the initial act, but as schools began to approach that deadline, many of them were failing to meet their goals. In 2012, President Obama began granting waivers to states. (See id.) By 2015, waivers were in place for 42 states, Puerto Rico, and the District of Columbia. (See "No Child Left Behind: An Overview," supra.)

As a condition of obtaining a waiver, states had to meet other requirements, including setting standards aimed at preparing students for the workforce or higher education. Some of these standards included the "Common Core State Standards" or getting their state's higher institutions of learning to certify that their standards are rigorous. (See id.) In addition, states were required to evaluate teachers in part based on their students' standardized testing scores and target at least 15 percent of schools with intervention efforts. (See id.)

NCLB only lasted for 14 years before it was replaced with the Every Student Succeeds Act (ESSA), signed into law by President Barack Obama in December 2015. (See NCLB, supra.) This new bill was a bipartisan effort, as many conservatives believed too much power was given to the federal government for education, which is viewed as a state-controlled issue, and liberals wanted to eliminate some of harsher penalties imposed on school districts and states for failing to meet the proficiency standards.

Parts of NCLB were kept, such as the mandated standardized testing in math and reading; however, the harsh penalties on school districts and states that performed poorly were eliminated. (Julie Hirschfeld Davis, "President Obama Signs into Law a Rewrite of No Child Left Behind," *N.Y. Times*, Dec. 10, 2015.) The federal government was barred from imposing academic standards like the Common Core State Standards; instead, it was left up to the states to determine what academic standards they would impose on their school districts.
There are still some federal standards and requirements, including for the lowest-performing 5 percent of schools and for schools where more than a third of high school students do not graduate on time. (See id.) Currently, states and school districts are implementing plans to conform with the new requirements under ESSA, but it has been heralded on both sides of the aisle as a major improvement over NCLB.

**Conclusion**

These few pieces of federal legislation are a glimpse into major events and news of the past 20 years that have had severe impacts on children. These three different pieces of legislation shed some light on how the United States views poor people and the faults that were laid at the feet of parents seemingly stuck in a cycle of poverty.

While there may have been good intentions behind each piece of legislation, the impacts on children and the poor have been mainly harmful as opposed to beneficial. The welfare reform act did not lift individuals out of poverty; it mainly kicked them off of much needed assistance, creating more severely poverty-stricken families and children. The CHIP program has increased the number of children who are insured, but CHIP and Medicaid recipients still face barriers to specialist and dental care. NCLB created a rigorous system with no flexibility that was destined to fail from the outset.

In the 20-year existence of the Children's Rights Committee, the common problems our children face are still the same: access to benefits, health care, and quality education. There has been tremendous progress in these areas, with advocacy work, policy changes, and increasing awareness of the problems our children face. Much good work has been accomplished; however, there is still much work to be done.

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Burnout: Avoidable, Not Inevitable

By Meloney C. Crawford and Douglas S. Querin

Burnout. You’ve probably heard the term many times, and possibly used it yourself to express boredom, fatigue or annoyance, as in “Not another feature article about incredibly successful lawyers. I’m burnt out on this stuff!” But those casual references fall short of describing the genuine distress that lawyers with burnout experience. It’s a condition that profoundly impacts their professional and personal life.

First, let’s determine what burnout is not. It’s not merely stress, although continuing, unrelieved stress can lead to burnout. It’s not ennui, although people experiencing burnout become disenchanted about work that they once found fulfilling and engaging. And, while an intense workload may be linked to stress, an individual in the extreme stages of burnout stops being productive—they’ve stopped in their tracks. Psychologist, author and speaker Joan Borysenko, Ph.D., recently published a book on the topic titled, Fried: Why You Burnout and How to Revive.

So, how to describe burnout to those who have never experienced it? Merriam-Webster’s online dictionary defines it as “exhaustion of physical or emotional strength or motivation usually as the result of prolonged stress or frustration.” In their book, Burn-Out: The High Cost of High Achievement, authors Dr. Herbert J. Freudenberger and Geraldine Richelson describe the condition as “a demon born of the society and times we live in,” adding that burnout “is not a condition that gets better by being ignored. Nor is it any kind of disgrace. On the contrary, it’s a problem born of good intentions.”

What Does Burnout Feel Like?

While everyone’s symptoms may vary, a common description one might hear is that it is “a feeling that I just don’t feel like I can do what needs doing. My creativity is gone, my energy is gone, and it is a burden to do anything.”

Burnout in the legal profession is greater than that of other professions, and perhaps now more than ever. In 2001, Martin E.P. Seligman and his colleagues Paul R. Verkuil and Terry H. Kang published an article, “Why Lawyers Are Unhappy” in the Deakin Law Review, noting the growing unhappiness of lawyers in the legal profession. They linked it to the competitive nature of the legal system, the high pressure and limited autonomy of new associates, and the essentially pessimistic nature of legal analysis, which centers on identifying and anticipating problems. In her Oct. 25, 2011 USA Today article, “Law Schools Pressed to Tell the Truth on Job Placement, Debt,” Mary Beth Marklein pointed out that a decade later, we are faced with a lackluster economy with fewer job opportunities for new graduates entering the legal
profession, often saddled with significant debt. This creates an environment for burnout to flourish. Lawyers feel a lack of control over their careers, whether it’s not working in the area they prefer, having to change geographical locations, or working long hours. On the job, they may experience a lack of communication or effective feedback about the work they do. Fewer opportunities for law firm employment lead more graduates to enter solo practice immediately after law school, and they either have too few clients, or are overwhelmed by demanding and difficult clients. According to author Anthony J. Cedoline in his book, *Job Burnout in Public Education: Symptoms, Causes and Survival Skills*, the resulting burnout is “a consequence of the perceived disparity between the demands of the job and the resources (both material and emotional) that an employee has available to him or her. When demands in the workplace become unusually high, it becomes increasingly impossible to cope with the stress associated with these working conditions.”

**Herbert J. Freudenberger** coined the term “burnout” and, with his colleague Gail North, described its general progression as following 12 stages:

1. A Compulsion to Prove Oneself
2. Working Harder
3. Neglecting One’s Needs
4. Displacement of Conflicts
5. Revision of Values
6. Denial of Emerging Problems
7. Withdrawal From Social Contacts
8. Obvious Behavioral Changes
9. Depersonalization
10. Inner Emptiness
11. Depression
12. Burnout Syndrome

Since Freudenberger’s 12 stages of burnout can appear abstract, let’s describe the progression.

Nearly every lawyer can recall having just passed the bar exam, beginning their first job and being determined to not only do their very best, but to outshine their peers. There’s no fault in ambition, but when it becomes a grim determination to show everyone around you that you are superlative in every way, the road to burnout begins.

Fueled by high personal expectations, you take on more work, volunteer for projects and dig in. Working toward a goal of being irreplaceable, you insist on handling everything yourself. As you
fill your day with work, work and more work, you begin to ignore your basic needs. You skip lunch, cut back on sleep and work weekends.

Soon, you may begin to sense that things aren’t going the way they should, but you don’t recognize that the real problem is your compulsive work habits and growing isolation. You may start to experience physical symptoms of distress, like headaches or sleep disturbance.

If the process continues without interruption, neglect of your personal needs leads to a sense of inner emptiness. While work and achievement were once important goals, people in the extreme stages of burnout can experience depression, as well as physical and emotional collapse.

That progression is intimidating, if not downright grim. But the solution can begin with a three-step process:

1. Recognize the situation, and the signs leading up to it.

2. Reverse the tide by reducing your stress and seeking support.

3. Find resilience by building up your “stress hardiness” by developing physical, emotional and spiritual resources.

Here are some specific ways to increase stress hardiness. One exercise that can be helpful, particularly when you are feeling dissatisfied or frustrated on the job, is to list the things that give meaning to what you do. Write down what attracted you to your current job or profession in the first place. List the things about it that you find fulfilling now. If you are currently at a low point, try to look back on when you first started and consider the big picture (e.g., how your job fits into your community and the world around you). Think about what you want to achieve with it and what you think is important to doing your job well. What gives meaning to your work? Focusing on the positive can help you endure frustration.

This doesn’t mean that stress hardiness is merely endurance. For the second part of this exercise, take a minute or two to vent. This may involve things like inadequacy of resources, lack of recognition or bureaucracy. In addition, list the factors that are causing you difficulty and are likely to cause stress in the future. How does your frustration list compare to your list of positive things about the job? What can you change? Where can you get support? What do you need to accept at this point in time?
Additional ways to avoid burnout include the many commonsense maintenance practices that, sadly, seem to be the first things that fall by the wayside when we are stressed. The short list includes getting enough sleep; eating a mostly balanced diet (allowing for the occasional treat); eating regular meals (coffee does not equal breakfast); and getting regular exercise (a brisk 15-minute walk morning and afternoon meets fitness recommendations).

**Keep in touch with friends.** Remember that while you can always make new friends, you can’t make old friends. These are the people with whom you share common history and memories. In this respect, technology can be useful by making distance irrelevant.

**Schedule vacations in advance.** Maintain healthy boundaries between work and home life. Nurture professional relationships. Expand your knowledge base by participating in seminars, workshops and continuing education. Schedule and attend annual checkups with your personal physician, eye doctor and dentist. Try to do something fun every day. It doesn’t have to be a big thing, just something that makes you smile. Nurture a positive attitude. Even though we are issue spotters and problem solvers in our profession, we don’t have to continually maintain legal vigilance. Remember—or discover—the things you are passionate about.

**What If You Are in the Final Stages of Burnout?**
You may feel isolated, hopeless and reluctant to talk to colleagues, friends or family members. Keep this in mind: Nearly every state in the United States has some form of Lawyer Assistance Program, ranging from volunteer peer support to programs with counselors on staff. Help for lawyers (1-866-LAW-LAPS) and members of the judiciary (1-800-219-6474) is just a phone call or email ([www.americanbar.org/groups/lawyer_assistance.html](http://www.americanbar.org/groups/lawyer_assistance.html)) away.

In his Resilience, Motivation and Family Relationships blog post, “Stressed Out or Stressed Hardy? Part 1,” Robert Brooks, Ph.D., stresses that our personal perspective is one of the most important components of stress hardiness, observing, “Why cast this concept of ‘stress hardiness’ in the framework of a mindset? The reason I do so is my strong belief that mindsets can be changed, that they do not have to remain fixed ideas that are cast in stone. I realize that many people have held on to certain self-defeating ideas for years, but with insight, courage and support these ideas can be changed.”

Joan Borysenko includes her own experience with burnout and recovery in her book, *Fried*, which she compares to the journey in Dante’s *Inferno*. Your personal experience may not be as dramatic, but her closing comments remind us all that the most difficult journeys frequently offer the greatest rewards: “Revival from burnout is always about the recovery of lost authenticity,” Borysenko said in her book. “It’s waking up to who we really are and realizing
that heaven is not a destination, but a state of mind. If being fried can bring us to a point where we reconnect to our own true nature, then it’s worth every moment of separation to rediscover the heaven that has been inside of us all along.”

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Sleep and Your Health
By Luisa Bazan, M.D.

Are you feeling run down? Have you been depressed lately? Overwhelmed by workload? Memory not so sharp? Problems with your blood pressure? It may not be just because you’re getting older. Lack of sleep or a sleep disorder could be the cause of your problems.

Human sleep can be defined as a state in which conscious awareness of the external world is lost, replaced either by an internally generated world of thoughts, feelings, and hallucination, or, at other times, by a true absence of consciousness.

The function of sleep is really a mystery; however, as with eating, drinking, and breathing, sleeping is a vital part of the foundation for good health and well-being throughout our lifetime. Research has identified that sleep is important for memory consolidation, immune function, and endocrine and thermal regulation.

How Much Sleep Do We Need?
The pressure of a deadline, high case load, concerns about clients, and working toward partnership can make for sleepless nights, but lack of sleep can slow down our thought process and make those sleepless nights less effective than we think.

Several studies have assessed performance after sleep deprivation through comparisons with different levels of alcohol intake. After 17–19 hours awake, human performance is equivalent to that of a blood alcohol concentration (BAC) level of 0.05 percent and after longer sleep deprivation, the level of performance reaches levels equivalent to a BAC of 0.1 percent. An alcohol level of 0.08 percent is the threshold for a DUI in most states.

In 2015, the American Academy of Sleep Medicine and the Sleep Research Society published a joint consensus recommending that adults should sleep seven to eight hours per night on a regular basis to promote optimal health.

Before the broad usage of the light bulb in early 1900, people used to sleep nine hours on average. Current surveys indicate that 35–40 percent of the adult US population report sleeping less than the usually recommended seven to eight hours on weekday nights and about 15 percent report sleeping fewer than six hours.

Sleep deprivation can be caused by sleep disorders, work schedules, and modern lifestyles. When we do not get enough sleep, or when we have poor quality sleep, we feel very tired throughout the day. Sleep deficiency can interfere with work, school, driving, and social
functioning. You might have trouble learning, focusing, and reacting. Also, you might find it hard to judge other people’s emotions and reactions. Sleep deficiency also can make you feel frustrated, cranky, or worried in social situations. Sleep deprivation also appears to play a role in chronic health diseases, such as dementia, cardiovascular disease, obesity, and type 2 diabetes.

How to Get Appropriate Sleep

Avoid stimulants. Caffeine is a powerful and readily available stimulant and is found not only in coffee but also in teas, cocoa, chocolate bars, and carbonated drinks. Read the labels on products you might consume in the evening to make sure they are caffeine-free. It is recommended to avoid caffeine four to six hours before bedtime.

Nicotine is also a stimulant drug, and smokers are recommended to refrain from tobacco products close to bedtime.

Alcohol depresses central nervous system function. It may help people falling asleep at the beginning of the night, but as the ethanol is metabolized, it produces withdrawal symptoms and may cause lighter sleep and arousals. Therefore, it is recommended to avoid alcohol four hours before bedtime.

Create an inviting sleep environment. Noise level, lighting, temperature, and air quality in the bedroom should be inviting to sleep. The bedroom should be quiet, dark, with a temperature between 65–70°F, and fresh air to promote sleep. A comfortable mattress and pillows are also necessary.

Avoid activities other than sleep and sex in the bedroom, which helps enhance the mental association between the bedroom and sleep. It is recommended to keep computers, TVs, and work materials outside the bedroom as well as pets that disrupt your sleep.

Establish a routine. Sixty minutes before bedtime, relaxing activities can start to ease the transition from wake to sleep time, such as light reading, TV, or relaxation exercises. Preparing a “To-Do List” for the next day to avoid thinking about those duties at bedtime can be helpful as well.

Go to bed when you’re tired. If you are not able to sleep in the first 20 minutes, get out of bed, go to another room to do something relaxing, and go back to bed after feeling tired again.
Don’t watch the clock. Set up your clock facing away from you. Looking at the clock when unable to sleep can exacerbate anxiety and make it harder to fall asleep.

Use light to your advantage. Light keeps our internal clock synchronized. Get exposed to light in the morning and through the day.

Keep a regular sleep schedule. A regular sleep schedule helps to ensure adequate training of the internal clock for a consistent time falling asleep and waking up. Keeping the awakening time consistent helps sleep the best. Even if the prior night’s bedtime was interrupted, it is best to wake up at the usual time. The extra sleep drive (the longer we are awake, the easier it is to fall asleep at bedtime) will help consolidate sleep the next night.

Avoid naps or nap early. If naps are needed, a short 20-minute nap before 5:00 p.m. can be helpful. If you have problems falling asleep at the beginning of the night, avoid taking naps.

Appropriate diet, hydration, and exercise are paramount. Hunger can cause wakefulness. That is why a light snack a little before bedtime can aid sleep. On the other hand, going to bed too full can cause wakefulness. Adequate hydration is also important. Water keeps us from waking up due to thirst, but not so much so close to bedtime that a trip to the bathroom is needed during the night.

Exercise is also important for general health and sleep. Exercising 20–30 minutes daily is recommended, but strenuous exercise before bedtime can wake up the nervous system and can lead to problems falling asleep. Adequate exercise three hours before bedtime is recommended.

How Can We Recover from Sleep Deprivation?
Life and responsibilities may sometimes prevent us from getting sufficient sleep. If we go through sleepless nights, for whatever reason, the following steps are recommended for faster recovery:

- Rehydration
- Light breakfast
- Minimize the use of caffeine
- Ensure that external distractions that can produce awakenings (smartphone alerts, telephone calls, doorbells, pagers) are managed
- White noise machines or low decibel music can help block out potential sounds versus ear plugs and eye shades
• Exercise early; heavy exercise can contribute to difficulty sleeping plus increase risk of injury

When Do You Need a Sleep Medicine Evaluation?
If, despite getting the right number of hours of sleep and following the right sleep hygiene, you are still feeling sleepy throughout the day, it is important to be evaluated by your primary care physician or by a sleep physician to make sure no sleep disorders are present that affect your sleep. Below are the more common pathologies.

**Insomnia.** About 30–40 percent of adults have some degree of disturbed sleep during the year. About 10–13 percent meet diagnosis criteria for insomnia in which the presenting features include difficulty sleeping at night and impaired functioning during the day. Insomnia is more frequent in females and the elderly, and it is also associated with other medical problems, especially mood disorders such as anxiety and depression. Adults with insomnia can have difficulty falling asleep or staying asleep, or a combination of both. Insomnia can produce daytime fatigue, excessive daytime sleepiness, difficulty concentrating, clumsiness, poor quality of life, or serious accidents. Treatment includes cognitive behavioral therapy or a series of techniques to help relaxation, initiation of sleep, and elimination of inadequate behaviors that perpetuate insomnia.

**Obstructive sleep apnea.** This disorder is characterized by partial or complete collapse of the upper airway, causing fluctuation in oxygen levels and sleep fragmentation. Patients usually present with history of snoring, breathing pauses, and excessive sleepiness through the day. A diagnosis can be made via a sleep study, and the treatment is lifelong and usually requires a medical, surgical, or behavioral approach. The most common therapy is the CPAP machine and weight loss.

**Restless legs syndrome.** This disorder can occur in 5–10 percent of the general population, and it can be associated with difficulty initiating sleep. Patients usually complain of an irresistible urge to move the legs during prolonged periods of lying down, usually in the evening. It is twice as common for women to have this disorder. Eighty percent of the time, it is associated with leg movements through the night and while sleeping, which is called periodic limb movement disorder.

**Narcolepsy.** Patients with this disorder are afflicted with intermittent, uncontrollable episodes of sleep during the day. They suffer of excessive daytime sleepiness, sleep attacks, sleep paralysis, the inability to move for several minutes when awakening, and hallucinations.
Parasomnias. These disorders are not usually associated with excessive sleepiness. This includes REM (rapid eye movement)-behavior disorder (acting dreams in the second half of the sleep period), as well as patients with non-REM parasomnias such as sleepwalking, sleep-related eating disorder, and sleep terrors.

If you experience any of the symptoms described here, you should consult a doctor to get appropriate treatment and improve your ability to get restful sleep. The alertness and sense of well-being that comes from a good night’s sleep makes us understand how important this function is for our health. Our bodies need sleep to rejuvenate, and our brains need sleep to prepare for the next day. Following the above recommendations can hopefully provide you with a better, healthier, and happier life.

Sleep well.

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PRACTICE POINTS

Addressing Discriminatory Discipline in Durham Public Schools

By Jessalyn Schwartz – March 6, 2018

Following an investigation by the U.S. Department of Education’s Office of Civil Rights (OCR) that lasted nearly 5 years, Durham Public Schools (DPS) in North Carolina has entered into a resolution agreement that will allow continued positive change and federal oversight of the school system. In 2013, the Advocates for Children’s Services (ACS) of Legal Aid of North Carolina, along with the Center for Civil Rights Remedies of the Civil Rights Project of UCLA filed a complaint alleging that DPS suspended black students and students with disabilities at a far higher rate than their white and non-disabled classmates.

During the course of the investigation, DPS began to take some positive steps towards remediating the effects of these discriminatory policies, such as arranging community forums, ordering an independent study of its practices and policies, and hiring a Director of Equity Affairs, among other efforts.

The formal resolution agreement sets forth specific steps the district must take in the next year, with continued monitoring by the OCR until at least September 2019. DPS must appoint a discipline supervisor to oversee disciplinary practices throughout the district, develop an Action Plan to ensure equitable treatment of all students facing disciplinary referrals and punishments, engage in data collection and self-monitoring, provide ongoing training to district staff focused on fair and equal disciplinary action, improve guidelines for school police, engage community stakeholders, and review alternative placement procedures.

The goal of the agreement is to combat the school-to-prison pipeline, improve the school environment, and create the opportunity for academic success for all students. This agreement has the potential to be a positive model for other districts across the country and may provide a framework for advocates to make meaningful change in communities impacted by inequity in school discipline and push-out. The support and backing of the OCR demonstrates a commitment within the Department of Education to combat this widespread issue and may signal a shift in response to complaints nationwide.

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What Lawyers Should Know about Federal Child Welfare Funding Changes

By Cathy Krebs and Sophie Prown – February 27, 2018

The continuing budget resolution enacted into law on February 9 contained significant changes to the way the child welfare system is funded. The Family First Act changes how Title IV-E funds can be used. Instead of solely being used for foster care and adoption assistance expenses, this money can now be used for 12 months of services aimed at helping families without the use of foster care (or with kinship care if needed). This allowance of funds shifts the federal focus to allow for services that could prevent children from entering foster care, when it is safe to keep them with their family. These funds will be released in fiscal year 2020 and will go toward evidence-based prevention measures, including substance abuse prevention and treatment, and toward in-home parenting skills services. Additionally, there had been no limit on how long IV-E could be used for congregate care, but now there will only be two weeks of federal support provided for congregate care. The hope from this change is that the preference will be for placing children in foster homes rather than in congregate or group homes. The Family First Act also reauthorizes the three grants of the Court Improvement Program through 2021.

Another change is that the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program, which connects professionals with new and expecting mothers to focus on strengthening their parenting skills, received a five-year extension at its current rate of $400 million per year. There was a real risk that this successful program would not be funded at all, so this unexpected funding was very welcome news for advocates.

Funds will also be aimed at children in foster family homes and other special settings. Children with special needs in qualified residential treatment programs will receive assessments and regular reviews to determine if their needs are still being met in that setting. While the funds will be made available in 2020, states have the right to delay these changes until 2022. They also have the flexibility to decide which safety services to provide and are able to determine their own process of ensuring children with special needs are receiving the appropriate services through qualified residential treatment programs.

New funding will be made available to relative caregivers through the evidence-based Kinship Navigator program, which connects relative caregivers with the support and services they may need to safely keep children with them. This also mandates that states document how their foster care licensing standards include relative caregivers. The Promoting Safe and Stable Families Program will receive funds for family reunification services (unlimited for children in foster care and 15 months for children who have returned home). States will also now be...
required develop plans for the tracking and prevention of child maltreatment fatalities. Finally, a grant program will be created to identify high-quality foster families so that more children can be placed in foster homes.

Other existing services benefiting from this budget resolution are the Regional Partnership Grant program (to prevent maltreatment due to substance abuse), John H. Chafee Foster Care Independence Program (for youth transitioning out of foster care), and measures to promote establishing permanent families for children in the system. Read a detailed summary of these additions and updates.

There is a staggered timeline for the implementation of these changes and services. Many updates will occur immediately and, by the end of this fiscal year, the Department of Health and Human Services will disseminate practice criteria for preventative services, as well as a list of preapproved services and programs, to aid states in their planning. At the start of fiscal year 2019, states will be eligible to receive IV-E reimbursements for up to one year for children who have been placed in a residential family-based treatment facility with their parent for substance abuse redressing. At this time, states can also claim a 50 percent reimbursement on evidence-based services used within the Kinship Navigator program. While states will financially start to recoup their expenses at this time, the onus will also be on them to implement more stringent tracking and monitoring of children and workers in facilities. The final implementation stage will be by the end of fiscal year 2027, when states will be required to participate in a digital interstate case-processing system to facilitate a transparent exchange of information to ease the placement of children outside of the home.

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http://www.americanbar.org/publications/litigation-committees/childrens-rights