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ARTICLES

Fighting Fear of Trump Administration’s Immigration Policies with Facts
*By Marisol Garcia and Eliza Presson – December 12, 2019*

For weeks, 13-year-old Juan (names and details have been changed to protect our clients’ identities) lay in bed, refusing to leave his room, even to eat or to shower. His mother, Maria, was terrified that her son was becoming more and more depressed. Maria and Juan had only recently arrived in Massachusetts after fleeing Juan’s abusive father in Colombia. Maria sought support and counseling services for her son, but, increasingly, Juan was too depressed to leave his room. Finally, a clinician recommended that Maria have Juan evaluated in the emergency room. Maria told her lawyer, “Juan is refusing to be screened by a mobile crisis team, even though he’s very depressed and won’t leave his room. . . . He’s afraid the hospitalization will be too expensive and it will be used against us in our immigration case. What should I do?”

Maria and Juan’s fear is rooted in confusion over recently announced changes in the public charge rule, which is used by immigration officials to determine whether a person can become a legal permanent resident. Advocates for children should make sure they understand not only the specifics of the public charge rule but also the broader climate of fear in which immigrant families are living, so that they can most effectively advocate for their clients and help families fight fear with facts.

Chilling Effects of the Trump Administration’s Immigration Policies

Like Juan and Maria, many families are fearful of accessing needed services for children from schools, social services, and the health care system. The public charge rule change is only one of many sweeping Trump administration changes to federal immigration law and policy that have intimidated, frightened, and confused some of our most vulnerable clients. While Trump’s campaign rhetoric focused on the construction of a border wall between the United States and Mexico, his executive orders and regulatory changes affect deportation, asylum, refugee resettlement, the admission of individuals from certain Muslim-majority countries, and multiple stages of the immigration process. Tragic images from migrant detention facilities proliferate in U.S. media directed at Spanish-speaking viewers. All these factors lead to an environment of general distrust of government and any government-related systems.

A December 2018 survey by the Urban Institute, a nonprofit research organization, captured some of the first formal data on the impacts of the proposed rule change on families accessing public services. According to its analysis, one in seven adults in immigrant families reported that
they had avoided participating in public benefits programs over the last year, out of fear that it would harm their chances of obtaining a green card.

Recent data from the Centers for Medicaid and Medicare Services (CMS) indicate that child enrollment in Medicaid and the Children’s Health Insurance Program (CHIP) is declining, and immigration and health care policy experts suspect that the Trump administration’s immigration policies may have affected that decline. CMS estimates that more than 1.1 million children dropped off from Medicaid/CHIP between December 2017 and June 2019. Historically, Medicaid enrollment increases during economic downturns but does not then shrink in bull markets. A drop in child enrollment is unusual and has occurred in only one year since 2000.

Anecdotally, over the past 18 months, advocates have reported that parents of children with disabilities are considering withdrawing them from special education or even declining to enroll them in school altogether. We have received many calls from immigrant parents fearful of signing forms that allow school districts to seek Medicaid reimbursements for special education services that students receive.

What Is the Public Charge Rule?
Long-standing federal immigration law provides that the federal government may deny a green card application for a U.S. resident who is likely to become dependent on the government for income—a public charge. Until the Trump administration’s proposed changes, the federal government defined public charge narrowly and considered the use of only two types of benefits: cash assistance for income maintenance, like Supplemental Security Income (SSI) and Temporary Assistance for Needy Families (TANF), and institutionalization for long-term care at government expense, like nursing homes. Other non-cash benefits have not historically been considered in making a public charge determination.

On August 14, 2019, the Department of Homeland Security published the new public charge rule, originally set to take effect on October 15, 2019. The new rule sought to expand the list of federal government benefits that count toward public charge status to include Medicaid coverage for adults, public housing, Section 8 housing assistance, and the Supplemental Nutrition Assistance Program (formerly known as food stamps), so that they would all count against applicants. In addition, specific time limits are imposed, such that the definition of a public charge is a person who is likely to need these specified federal benefits for more than 12 months in any future 3-year period.

Many federal programs are not considered, even under the new public charge test, including Medicaid received by children under the age of 21, emergency medical assistance, school lunch
programs, food pantries, and disaster relief. All special education services provided under the Individuals with Disabilities Education Act (IDEA) also are explicitly excluded from consideration.

Similarly, many immigrants are exempt from the public charge test. It applies only to U.S. residents who are applying for a green card. Family members’ receipt of benefits also does not count against the applicant.

Prior to the October 15, 2019, effective date, immigration advocates across the country filed legal challenges, and injunctions issued by multiple federal courts postponed implementation indefinitely, as the cases make their way through the court system.

How This May Affect Juvenile Attorneys’ Representation
While attorneys may not ask, or want to ask, the immigration status of their child client, they should be aware of the concerns of this vulnerable community. Access to social services is often critical to a positive outcome in a juvenile court matter. It is important that attorneys inform themselves to help allay their clients’ fears and fight rhetoric with fact. Here are some important pointers:

1. The public charge test is not part of the U.S. citizenship application. Clients with green cards are not at risk. It’s also not a test given to determine deportation decisions. A U.S. resident must apply for a green card before immigration officials would apply a public charge test.

2. Although the fear of accessing special education services and health care is very real, the threat is not. The changes in the public charge rule specifically exempt IDEA services and Medicaid for children under the age 21. Anyone—with or without a green card—can avail themselves of the special education and health care services to which they are entitled.

3. Right now (as of December 2019), the proposed rule change has been enjoined: Health care, nutrition, and housing benefits cannot be used to deny a green card to an applicant on the basis of public charge status. The public charge rule as it is currently formulated applies only to benefits like SSI, TANF, and institutionalization for long-term care.

4. If the proposed public charge rule does go into effect, non-cash benefits used before the effective date cannot be considered. The effective date will not be retroactive.
Sadly, the data suggest that the anti-immigrant rhetoric of the Trump administration has already affected the access of families to critical social services. Our work as advocates for children and families is to remain informed and educate our clients so that kids get the care that they need and remain entitled to under the law.

The authors would like to thank Andrew Cohen, director of Health Law Advocates Immigrant Initiative, for his technical assistance on this article.

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A Place for Bullying Protections in School Lawyering
By Jackie Ross and Miranda Johnson – December 12, 2019

Bullying is a significant challenge facing our schools: One in five students report having experienced bullying, and, according to the same article, rates of cyberbullying have also increased, particularly among girls, who are more likely to report being harassed online or by text message. Bullying of certain vulnerable school populations is also a particular concern; recent surveys show that increasing numbers of students of color attending predominantly white schools have reported being bullied. In addition, both students with disabilities and lesbian, gay, transgender, bisexual, and questioning (LGBTQ) youths are also particularly vulnerable to being bullied.

Bullying can have a serious impact on a student’s mental and physical health, changing that student’s trajectory. According to the Centers for Disease Control and Prevention, bullying increases students’ risk for anxiety, depression, substance use, and academic problems. Bullying can contribute to students’ refusal to attend school and result in physical problems such as headaches, stomachaches, and sleep disruption. In extreme cases, it has led to students commit suicide or become violent. A recent report of the U.S. Secret Service’s National Threat Assessment Center found that most school shooters were bullied.

Throughout the country, states have enacted laws designed to prevent and respond to bullying and cyberbullying. While each state addresses bullying differently, most states require school districts and schools to develop policies to investigate and respond to bullying. Some states also require the implementation of bullying prevention programs.

Despite state and local provisions relating to school bullying, many affected families lack knowledge of available bullying protections and find that schools do not take their complaints seriously. When parents do report bullying, school investigations are often lackluster, with the result that complaints are frequently dismissed for lack of proof or corroboration.

When schools do intervene in response to bullying complaints, interventions often impose punishment on the other student through suspension, expulsion, or alternative school placement. These remedies typically do not address the root causes of power imbalances between students and may still leave a targeted classmate vulnerable to bullying online, in the community, or upon the other student’s return to the school. Moreover, punitive measures focused solely on the individual students involved in a bullying incident do little to engage other stakeholders or foster the creation of a positive school climate, which research suggests is vital to protect students from bullying.
Here in Illinois, where the authors work and study, few attorneys practice in the area of school bullying. Recognizing this gap in legal representation, our legal clinic, the Civitas ChildLaw Clinic at Loyola University Chicago School of Law, recently began representing bullying victims. In this article, we discuss the development of legal protections for bullying victims and share two case examples illustrating the potential for achieving positive outcomes. Though bullying cases may seem modest in their scope, legal advocacy can yield impactful outcomes, not just for the involved students but also for school staff and the student body as a whole. By highlighting these examples, we hope to encourage more family and school-side attorneys to see the value in this work.

**Background and Context**

At Loyola University Chicago’s Civitas ChildLaw Clinic, law students working under the supervision of experienced clinical faculty provide legal representation to children in a range of legal proceedings—child welfare, domestic relations, education, and other areas.

In the fall of 2014, the ChildLaw Clinic and the Chicago Lawyers’ Committee for Civil Rights collaboratively launched the Chicago “Stand Up for Each Other” (SUFEO) project. Modeled on similar projects developed in New Orleans and New York, SUFEO began as a student-run organization that provides information to parents and kindergarten through twelfth-grade students on their rights relating to school suspensions. The project aims to facilitate dialogue between parents and schools to help students remain in school and be more successful moving forward. SUFEO engages 1Ls and 2Ls in this work, as a way of exposing students to outreach, intake, and advocacy early in their law school careers.

During the 2018–2019 school year, SUFEO and the ChildLaw Clinic added bullying cases to their school suspension work. Our advocacy has focused on cases in which the targeted client’s goals are to seek protection and support, rather than to punish the student engaging in bullying behaviors. The ChildLaw Clinic’s work relies on a series of bullying laws passed in Illinois, most notably the Prevent School Violence Act, which was enacted in 2010. This law defines bullying and specifically prohibits bullying based on actual or perceived characteristics, including race, national origin, disability, sexual orientation, and gender-related identity or expression. The law requires each school to adopt a bullying policy consistent with the act.

The clinic has also relied on the Anti-Bullying Policy adopted by Chicago Public Schools (CPS). This policy comprehensively outlines the steps required for a bullying investigation, including individual interviews of all involved parties in a private setting. The policy also outlines a comprehensive response:
• identifying school risk factors for bullying and developing a comprehensive strategy for school climate improvement and social-emotional learning;

• supporting the targeted student through the creation and implementation of a safety plan;

• if the student has a disability, convening an individualized education program (IEP) meeting to consider whether the student requires additional or different special education supports to address concerns like social skills and other risk factors creating vulnerability to bullying;

• implementing interventions and consequences that address the root causes of the bullying behaviors exhibited by students; and

• for incidents affecting the school community, creating spaces to discuss the incident, its impact, and how any harm can be repaired.

The CPS code of conduct also expressly stipulates responses that should not be taken, such as dismissing student behavior as not serious, assuming that bullying has no impact, soliciting an apology, or engaging in peace circles or mediation between the students. The code of conduct recognizes that in a bullying situation, the inherent power differential between students limits the utility of many forms of alternative dispute resolution; therefore, the code prohibits using mediation or restorative practices to bring the students together unless interventions have been taken to address this differential.

The two cases below illustrate the range of issues and challenges that may arise during the course representation in bullying cases.

Robert’s Case
In March 2019, a frustrated parent, Pam, called the ChildLaw Clinic in search of legal advocacy for her fourth-grade son, Robert. Robert, who is African American, was being targeted with homophobic and racial slurs at his school, which served mostly Latinx students. Interactions with the other students turned physical on multiple occasions. At some point, one student shared in front of the class that her mom told her not to play with Robert because he was black. The teacher, unsure of how to respond, changed the topic.

Pam requested meetings with both school administrators and the parents of the students engaging in bullying behavior toward her son, but before our engagement, there had been no meaningful follow-through on these requests. Pam was concerned that the school did not
appear to take seriously her concerns regarding other students’ actions toward Robert. In contrast, whenever the school had concerns about Robert’s behavior, Pam immediately received letters and phone calls discussing possible disciplinary actions.

When the ChildLaw Clinic became involved, it was evident that Pam was at the end of her rope. She was concerned that Robert’s grades were declining because of these experiences. Robert felt that the principal did not like him, and he was apprehensive about attending school functions where he was certain to see her.

At the time Pam called our office, she had already filed a bullying complaint with the school district and she was seeking representation at an upcoming meeting with school and district staff. When our office agreed to represent the family, the school district also sent its lawyer.

The first meeting was volatile. Both the parent and the school were extremely frustrated, and the relationship had completely broken down. Our office engaged in a collaborative problem-solving model of lawyering with the school district attorney and school and district staff. Our efforts focused on the creation of a comprehensive safety plan, staff training, and steps to foster a more culturally sensitive school climate. During that initial meeting, the parent agreed to provide the school with a full log of all past bullying incidents, and the school agreed to investigate those incidents using the protocols outlined in the CPS Anti-Bullying Policy. The parties agreed to reconvene to discuss the results of the bullying investigation and create a safety plan for Robert.

After that initial meeting, we met with the school district team five more times over the following six-month period. At these meetings, we discussed the progress of the bullying investigation, additional incidents that had arisen, the school’s response, and the school district’s progress in implementing broader remedies. The school substantiated many of the allegations of bullying, and the school and parent agreed to the following:

- Creation of a safety plan to protect Robert from bullying, with particular attention to time during recess and after-school activities when most of the bullying incidents occurred. During these time periods, the school designated a staff member to whom Robert could report bullying.

- The monitors supervising unstructured time would be appropriately trained on how to work with children and on how to report bullying in accordance with the district’s procedures and protocols.
School personnel would undergo professional development training regarding biased-based bullying, both online and over the summer.

The students would be taught about biased-based bullying. The school would also expand its focus on Black History Month and offer programming in a manner similar to the school’s celebration of National Hispanic Heritage Month.

There were a number of challenges throughout this process. It took a great deal of advocacy to ensure that the bullying investigation was properly conducted, and the parent and the school district disagreed about some of the findings. For example, the school determined that some of Robert’s allegations of bullying were unsubstantiated solely because no other students or staff had heard or observed the incidents in question. Rather than evaluating whether Robert’s accounts of the incidents in question were credible, investigators discounted Robert’s claims solely because the other students denied them and there were no corroborating witnesses.

In addition, it took a great deal of time and collaboration for the school staff to recognize the purpose of a safety plan. School staff sometimes attempted to put restrictions on Robert’s movements, rather than restricting the movements of the students who had engaged in the bullying behavior. As a result, Robert was at times separated from his friends and forced to stand by his teacher. He began to feel like he was in trouble and that he had done something wrong by reporting his experiences at school. This issue was addressed at a meeting, and the administration was receptive to making requested changes to the safety plan.

The ChildLaw Clinic conducted a follow-up meeting at the school this fall, about six months after the initial meeting. In this meeting, Pam shared that her son finally had his “sparkle” back. Both Robert’s good grades and his desire to go to school had returned. Through this process, a 1L student advocate, who started out mainly observing a 2L on the case, built her knowledge and confidence and was able to take the lead role in the meeting as a 2L.

Aaron’s Case
Aaron’s mom, Jessica, contacted our clinic in the spring of 2019. Like Robert, Aaron was a fourth-grade student who was getting into trouble for behaviors prompted by his being teased by peers at recess. After one incident, the school suspended Aaron for several days. Our clinic represented the student in a suspension appeal and in a meeting to develop a safety plan. The suspension was upheld; however, the school finally acknowledged that Aaron was being targeted by other students. The school reasoned that Aaron’s poor social skills triggered students and caused them to lash out at him.
The school implemented a safety plan that included provisions for more adult monitoring during unstructured times such as lunch and recess. The plan also included a check-in/check-out (CI/CO) system, whereby Aaron checked in for five minutes in the morning with a trusted adult and five minutes in the afternoon before leaving the school. As a result of these relatively simple interventions, Aaron’s negative behaviors and experience of bullying diminished significantly, and school staff reported that the CI/CO system appeared to help stabilize him during the school day.

In addition, the school had not considered special education eligibility or the need for related services for Aaron, likely because Aaron performed so well on standardized tests. We urged the school to recognize that the noted social deficits and the gap between his grades and test scores suggested that Aaron might be a student with a disability in need of services. The school agreed to conduct an evaluation to consider special education eligibility. Jessica also secured an outside evaluation for Aaron.

The evaluations revealed that Aaron was “twice exceptional.” Aaron was diagnosed with attention-deficit/hyperactivity disorder (ADHD), unspecified disruptive impulse-control, and conduct disorder. These disorders made it difficult for Aaron to concentrate in class, turn in assignments, and behave appropriately during unstructured periods at school. Aaron qualified for special education services as a student with an “Other Health Impairment.” He was given paraprofessional support during lunch and recess, time with a special education teacher to improve executive functioning, and social work to increase his skills in this realm. A behavior intervention plan (BIP) was designed to help redirect Aaron’s problematic behavior and, based on the successful experience implementing the safety plan, provide regular check-ins throughout the day with a staff at the school.

In the fall of 2019, we had a follow-up IEP meeting with the school. Over the span of just a few months, the tone of the school meeting had transformed into an extremely positive one. School staff were proud of Aaron, his behavior, his grades, and his overall improvement. The staff explained how Aaron was thriving with this highly structured routine. The BIP had properly trained staff on Aaron’s challenges, which allowed them to catch Aaron’s frustrations before they erupted into a physical altercation with another student. Aaron’s grades had also improved to a level where he could potentially test into the school’s gifted program next year. Due to the increased supports, Aaron’s teachers no longer see him as a burden in their classes. They recognize his strengths and contributions to his classroom and school community.

Since these meetings, Jessica reports she has more confidence in advocating for her son’s needs. She shared, “I always tell them I have the best team of lawyers on my side, and that makes them listen now.”
Our Takeaways
These two cases highlight several themes that have emerged in our work on bullying cases. The first is the importance of taking an approach focused on positive, social-emotional strategies rather than a punitive approach. Based on the ChildLaw Clinic’s long-standing work on behalf of children, we understand that misbehavior of children is normal, expected, and developmentally appropriate, and that it is the role of school staff to teach students positive social and emotional skills to respond to emotions that they are experiencing. In addition, when young people have mental health needs and have experienced trauma at home or in the community, they need additional supports at school in order to be successful. We see bullying cases as an opportunity to build positive social-emotional strategies aimed at addressing the root causes of bullying behaviors.

In addition, we have seen that addressing bullying requires school-wide strategies so that staff and teachers can become better equipped in responding to bullying when it occurs. Achieving school-wide training and cultural changes is far more likely to arise from collaborative problem solving than from an adversarial approach. We have been able to work with school staff and with social-emotional learning specialists from the district to explore gaps in training and to link schools to training resources.

We have also seen the value of a robust safety plan, focused on building supports for bullied students and on managing times when they come into contact with students engaged in bullying behavior. Often the initial draft of a safety plan takes a “blame the victim” approach, where the focus is on minimizing the behaviors of the student who is the target of the bullying. It is also very common for a safety plan to put the onus entirely on the student to inform staff of the bullying. Schools will defend this tactic, saying it is important for students to develop “self-advocacy.” While we strive for youth to work toward independence, students must also be able to focus on their learning. Ultimately, it is the staff’s responsibility to ensure a safe environment for their students.

We have also found that many of the problems related to school bullying occur during unstructured time. Some schools use less-trained staff, volunteers, or outside staffing agencies, rather than teachers or experienced school staff, for less structured periods, such as school drop-off time, recess, and after-school programming. These staff, volunteers, or substitutes may not receive the same level of training and professional development opportunities as regular school staff. In Robert’s case, for example, the school hired Spanish-speaking parents from the community to monitor recess and lunch, without realizing that they did not have a single bilingual monitor, leaving English-speaking students feeling that they did not have anyone with whom they could speak if a situation arose. It is also likely that schools do not
adequately orient volunteers or substitutes to their students’ special education needs, leaving schools open to disability-specific claims. Usually, just citing these issues is enough to get the school to agree to use better-trained volunteers to monitor lunch time, recess, and after-school programming.

Taking on bullying cases can be an upstream approach to lawyering, allowing for schools to address the student’s educational concerns before the student’s educational trajectory has been fundamentally altered. While the relationships between the parent and the school may be frayed in these types of cases, they are frequently not beyond repair.

Our experience has also illustrated that these cases are a good fit for law students and pro bono attorneys. Because of the nature and scope of the issues, we have achieved success with relatively straight-forward school-based meetings, such as bullying complaints, suspension appeals, safety planning meetings, or IEP meetings for students with disabilities. While other areas of education law can be very technical, this work often demands strong communication, case management, and problem-solving skills, as well as common sense. These are attributes that do not require extensive grounding in education law.

Law students have shared how fulfilling they find these cases to be and report that their cases reconnect them to what brought them to law school in the first place. Through working on these types of cases early in their legal careers, law students are able to practice legal skills like client intake, records review, professional email communication, and advocacy. They feel personally and professionally rewarded for the work.

**Conclusion**

In today’s world, the stakes are too high to continue to dismiss bullying as a benign reality of childhood. When teasing becomes bullying and interferes with a student’s education or well-being or both, there are legal tools available to protect affected students. Using these strategies can help create a paradigm shift in schools so children can feel safe, engaged, and able to learn.

*Jackie Ross is a staff attorney and Miranda Johnson is a clinical professor at the Civitas ChildLaw Clinic at Loyola University Chicago School of Law.*
Using Reflective Case Consultation to Battle Burnout and Secondary Traumatic Stress

By Kim Cobb, Elise Melrose, Alison Stankus, and Alexandra Vargo – December 12, 2019

As advocates for children, we are “under pressure”: We are the voice for the most vulnerable in a vast and complicated configuration of systems. The issues we face as children’s lawyers are immense, and not ones that attorneys in other practice areas generally confront through their work on a daily basis. Each client’s individual experience illustrates our societal problems: poverty, substance abuse, domestic violence, severe neglect, mental illness, physical abuse, sexual abuse, human trafficking, and sometimes death.

Due to these experiences, the clients we represent often have complex trauma histories beyond the scope of what any child (or adult, for that matter) should endure. Just when we think we’ve heard or seen it all, there is another client who has experienced a situation that baffles, angers, and saddens us. We look into the eyes of our clients; we hear their voices recount the unimaginable and experience the hard truths of their lives. We revel when the protective factors for which we advocate bring forth resilience in our clients. We are discouraged and may feel responsible if our advocacy is not enough to mitigate the long-term impact of their trauma. As Laura van Dernoot Lipsky writes in her book *Trauma Stewardship: An Everyday Guide to Caring for Self While Caring for Others*, we are “transformed” by this work—“the world looks and feels like a different place” as result of it.

Exposure to these issues through our work leads to secondary traumatic stress (STS) in children’s lawyers. In a fact sheet, the National Child Traumatic Stress Network describes STS as emotional duress that is a result of hearing another’s first-hand trauma experiences. STS is caused by “second-hand” exposure due to the work we do every day as advocates for abused and neglected children: hearing stories and narratives of traumatic events, reading case files, and eliciting testimony in court.

STS is unavoidable if we are immersed in our work with trauma-impacted children and families. It can develop into symptoms—such as hopelessness, hypervigilance, avoidance of clients, anger and cynicism, sleeplessness, chronic exhaustion, and guilt—that can mimic those of post-traumatic stress disorder. Further, STS and its symptoms can accumulate over time and lead to compassion fatigue and vicarious trauma, more than just burnout or general occupational stress. We can become desensitized toward our work, and STS can build up to become an occupational hazard. We chose to become children’s lawyers because we have a fervent desire to ensure children’s safety, well-being, and permanency. Yet, we likely didn’t fully understand
the impact this work would have on us. How do we sustain ourselves in the face of STS to continue on our relentless quest to improve the quality and dignity of our clients’ lives?

**What We Are Doing**

The Office of the Cook County Public Guardian comprises three divisions—the Juvenile Division, the Adult Guardianship Division, and the Domestic Relations Division—that are devoted to championing the rights of children and adults with disabilities. In the Juvenile Division, our office is appointed as attorney and guardian ad litem for about 6,000 clients ranging from newborn to age 21 in child abuse and neglect proceedings in Cook County, Illinois. The division has some 60 lawyers and a multidisciplinary team of paralegals, social workers/case advocates, psychologists, investigators, and support staff.

Due to the confidential nature of our work in child abuse and neglect proceedings, it can be incredibly difficult to share the trauma that our clients experience (and that we hear or read about on a daily basis) with our normal supports, such as family or friends. Even when we can share generalities, we fear that our normal supports won’t understand, or we don’t want to burden them with more stories of injustice or suffering. We may also worry about “slimming” our coworkers—unloading our experience of a client’s trauma on them when they might already be experiencing STS themselves. But we must acknowledge that STS affects all of us, and to ensure that we continue to advocate zealously for our clients, we must address it.

The first step toward addressing STS was recognizing, as the saying goes, that it is an issue. In 2014, our office was approached by the Children’s Research Triangle, a Chicago-area mental health service provider, which had received a grant from the Bright Promises Foundation. The goal of the grant was to work with partner agencies to help further integrate trauma-informed knowledge and practice into the fabric of each organization. For our organization, clinicians from the Children’s Research Triangle facilitated a series of trainings focused on recognizing and developing foundational tools and strategies to cope with STS, compassion fatigue, and secondary trauma. These “cost of caring” trainings were mandatory for all staff in the Juvenile Division, from supervisors to our clerical support staff, and the sessions were tailored to an individual’s role in the office. For example, supervisors received training that incorporated discussions on the additional challenges of supervising attorneys affected by secondary trauma, while also likely experiencing STS themselves. Through the trainings provided by the grant, it quickly became apparent that STS was greatly affecting not just us as children’s lawyers but our staff as a whole.

After the grant ended in 2017 and our entire staff in the Juvenile Division had participated in and benefited from the trainings geared toward addressing the secondary trauma we all experienced, the four of us set out to carry on the tenets of the grant. Specifically, we wanted
to ensure that our organization continued to recognize the effects of STS on our staff and provide an outlet to address it. With guidance from the Children’s Research Triangle clinicians and by adapting a model by Richard L. Hester and Kelli Walker-Jones from “A Reflecting Team Method of Case Presentation,” we developed and implemented the Reflective Case Consultation (RCC) process to address STS among attorneys and other staff in our Juvenile Division.

What we now call “RCC” is a one-hour reflective session designed to provide a safe space for lawyers and staff to share their experiences of STS. The process consists of four roles for participants: presenter, listening partner, reflective team, and timekeeper. The presenter volunteers to share his or her experience with the group and raises internal struggles, questions, and concerns—initially just with the listening partner and then with the larger reflective team. The listening partner asks questions of the presenter that focus on the inner experience of the presenter, rather than on judgment or supervision. The reflective team listens to the discussion between the presenter and the listening partner, and then talks among themselves about the presenter’s experience. The timekeeper is charged with managing the time and participates as part of the reflective team. The focus of the session as a whole is on the experience of the presenter—not supervising, fixing, diagnosing, or directing the issue or case.

We begin each session with a brief introduction to explain the process and discuss the ground rules—including that the forum focuses on support and encouragement of each other, rather than on judgment, and is meant to be a safe space. Next, the presenter and listening partner speak as if they are alone for 15 minutes about the presenter’s case, while the reflective team listens silently. After a minute of silent reflection, the reflective team then speaks for 10 minutes regarding the presenter’s struggles or concerns. The presenter and listening partner remain in the room and listen to the reflective team’s discussion. Following another minute of silence, the presenter and listening partner again speak alone for 5 minutes to process what they heard from the reflective team. Then, the entire group comes together—presenter, listening partner, and reflective team—to discuss each other’s experiences as they relate to the presenter’s case. The end of each session is dependent on the course of the discussion. At times, we have used silence or meditation to end the session, but for most sessions, staff have so much to share with each other that we run out of time and (without even trying) end on a positive note of shared experience. For more information on the process, see the "The Reflective Process—Guide".

We schedule RCC as a monthly opportunity for our lawyers and staff, and the management of our organization encourages staff to take the hour to process and address STS. In preparing for each session, we provide a related article or reflection for participants to read, and despite
using a conference room, we try to make the room as tranquil as possible through air diffusers, portable fountains, and baked goods or treats.

We encourage staff members who attend to volunteer as the presenter, but we also come prepared to present. One of the four of us is always the listening partner—a role that we’ve sometimes found to be difficult, given that most of us are attuned to focus on solving problems, rather than simply listening and focusing on the presenter’s internal struggles. We also offer a list of suggested topics for presenters to help identify an issue or concern to discuss. Some examples of suggested topics are our experiences of our client’s or client’s family’s trauma; stressful issues as advocates in the child welfare profession; gender, racial, and cultural issues that arise in our work; and systemic competence issues, including engaging with other professionals.

**Why It Works: The Impact of RCC on Our Staff and Practice**

It is not always easy to introduce new projects, especially those that make individuals reflect and share. Many of our lawyers and staff were skeptical at first, and some probably still are. Some initially thought that the sessions were just for venting or complaining or that they were just another task on their to-do list. These initial responses to the project made clear that the first step toward having any success was to have internal support from our administration. Once we had this support, it allowed us to provide a consistent time and space for monthly sessions to be held. The consistency of the facilitators and the process at every session has been crucial.

Everyone in our office knows when the sessions are held and who will be facilitating. Though we have consistency, we never know how our colleagues’ days will go. Court hearings, meetings, client visits, record reviews, and phone calls can be filled with brand-new trauma exposure. One day someone might not want to talk about anything, and other days that person may be bursting at the seams to share. We try to make attendance as easy and beneficial as possible. Staff are welcome to attend the open sessions without signing up in advance, with no expectation of participation, and with an expectation of privacy. Those who attend may wish to present and share, listen and provide feedback, or just simply listen.

Sometimes merely listening to what our colleagues are experiencing can help us feel less alone. It can increase our awareness that our colleagues are also experiencing STS and dealing with or processing it in their own ways. Any level of participation allows us to be there for one another and to acknowledge that it is OK to talk about our exposure to STS and the fact that it affects us all.
One of the ground rules for RCC is that attendees do not talk about what happened during the session once they leave. We have worked hard to keep RCC a “safe space” where what is talked about in the session stays in the session. We have also worked hard to distinguish RCC from our regular chain of supervision, keeping the sessions focused on the experience of the presenter and the feelings the experience brought up for the presenter and the reflective team. We redirect our inclination as lawyers to diagnose, advise on, or fix those experiences, as that certainly has or will happen in separate meetings outside of the session.

We have been able to maintain attendance through word of mouth and by building a positive reputation. We have also been able to get new faces in the room and have consistent attendance by offering continuing legal education (CLE) credits to lawyers who attend. In Illinois, earlier this year we completed our first reporting period where one of the required categories of continuing education credit is “mental health and substance abuse,” a subcategory of our professional responsibility credit requirements. RCC qualifies for this specialty credit for lawyers who attend. We realize that some lawyers may attend because they need that hour of CLE, and that is fine with us—we believe that every single person in the room receives a benefit from the session, no matter their reason for attending.

Over time, we have seen a cultural shift in our office. Those who have attended often come back again and again. Providing a time and space for these structured sessions with support from our administration has allowed our lawyers and other staff to openly discuss how our work affects us. We have been able to acknowledge and reiterate that STS is not a sign that we are not cut out for this work or that we are not able to do our jobs well. Rather, through RCC we are slowly and collectively recognizing that it is OK to admit the presence of these symptoms not just to ourselves but to our colleagues and even our supervisors.

Evaluations are a required part of our course offerings to receive mandatory continuing legal education (MCLE) credit, and they have been especially useful to gauge participants’ true feelings and reactions to the reflective process. For example, it may be hard to tell how a participant who is not speaking as much as others is experiencing the sessions. Feedback from our sessions has included statements such as these:

- “Words cannot express the value this training has added to my work experience.”
- “Need more time! I love being able to ‘exhale’ in these sessions and not feel judged.”
- “[T]his [session] far exceeded my expectations. The structure helped me more than I thought it would. At times, I had tears in my eyes.”
“We all went through processing the emotions—feeling the frustration and lack of control we all feel—in a very universal way.”

“[The presenter] was brave, and I think this is the start of something great.”

“Thank you for this outlet!!”

Effects on the Profession
Even seasoned lawyers sat back after the initial round of grant-funded training and had an “ah-ha” moment of identifying with the experience and symptoms of STS, realizing “that’s why I’m feeling this way” or “that’s why I’m having this reaction.” While we may all vent about the frustrations of being a children’s lawyer, STS is more than that—and we don’t know that others are experiencing it unless we talk about it. Making the initial “cost of caring” trainings mandatory gave all our staff a common language to use when talking about how the work affects us, helping us identify symptoms of STS both in ourselves and in our colleagues. The RCC sessions also have helped to create an office-wide model of a safer and more reliable option for debriefing our work with colleagues.

Unfortunately, the legal profession overall has only in recent years begun to address wellness among its members. When Illinois announced in April 2017 that attorneys would need to complete CLE on mental health and substance abuse topics, it was one of only three states requiring attorneys to complete some form of mental health and substance abuse education. The Illinois Supreme Court Commission on Professionalism amended the MCLE rules to include this category to both address the profession’s lag in addressing wellness among its members and encourage course development on this subject. In the announcement issued on April 3, 2017, the Illinois Supreme Court found that “lawyers were not seeking out or cannot find continuing legal education programs that might offer meaningful help in addressing [their own issues or those of their colleagues].” Education is the key to reducing the stigma of STS among children’s lawyers and the legal profession as a whole.

Conclusion
We cannot do this work for very long—at least do it well for very long—without being affected by STS. We need to maintain seasoned children’s lawyers while developing new members of the profession who will want to stay and commit to this difficult work for their career. We have found that both experienced attorneys and new hires attend RCC and that they use the outlet of the sessions to sustain them. We also are beginning to implement the “cost of caring” material into our training protocol for new hires as well as hold initial reflective sessions for them. Our hope is that what has been a “cultural shift” for those of us who have been in the office through this journey will become the normative way of practicing for our new lawyers.
We believe that RCC is an effective tool to battle burnout and STS and that it is an important tool in elevating our practice and our profession.

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L.A. County’s Juvenile Mental Health Court: A Unique Approach to Reducing Recidivism

By Kelly Rain Collin – December 12, 2019

Prenatal exposure to alcohol and other drugs, years of abuse and neglect, bouncing from one home to another in the foster care system, struggling in school due to unidentified learning disabilities, wanting to belong, trying to fit in, following the wrong crowd, experimenting with drugs, participating in illegal activities, truancy, getting in trouble with the law—these are the common precursors for youths entering the Juvenile Mental Health Court (JMHC) in Los Angeles County. How can anyone effectively address the complex and ever-changing needs of these youths? Simply put, one person cannot.

The creators of the Los Angeles County JMHC saw the need for a multidisciplinary team to effectively address the many unique and significant needs of these youths and brought together professionals from the fields of psychiatry, psychology, education, probation, law, and social work. This multifaceted team works collaboratively to address the needs of the youths.

Because of the severity of needs in the youths served, the JMHC team sees the youths much more frequently than typical courts in order to monitor their progress and any changing needs. Youths are typically brought into court every two to four weeks when they first come to the JMHC, and less frequently as their behavior improves and their needs lessen due to the successful implementation of services. The JMHC allows for variation in the youths’ behaviors as they work toward sobriety or are delving into their trauma history with a therapist, with the understanding that recovery and behavioral change are not a straight line, but rather a sometimes bumpy path. The JMHC team works to support the youths as they navigate this new path and try out their new skills. If a youth needs intensive support, the JMHC team has the flexibility to provide that support by seeing the youth more frequently in court, collaborating with outside services, or spending time talking with the youth directly, or a combination of these.

There are about 50 juvenile mental health courts operating throughout the United States. Each is structured slightly differently, serving different subsets of youths in various ways. A list of these courts can be found on the website of the Substance Abuse and Mental Health Services Administration. This article is specific to the approach of the JMHC in Los Angeles County, California.
The Team
All of the personnel on the JMHC team have not only professional expertise in their field but also significant experience and understanding of mental health and developmental disabilities and how these may manifest within a youth’s behavior.

Effective conversations with the youth are facilitated by having a judge who is knowledgeable about mental health and has an appreciation of how developmental delays may affect a youth’s communication and social skills. The judge is able not only to take the time to talk with the youth and listen to his or her needs but also to listen through a lens that allows the judge to understand how and why the youth may be responding the way he or she is. The judge is able to perceive how the mental health issues or the cognitive challenges may have affected the youth’s behavior and choices and use this to inform the court’s approach to interventions. Understanding this allows for an insightful and supportive mix of empathy and structure.

The number of youths served and the intensity of support provided requires two full-time probation officers dedicated solely to the youths of the JMHC. These probation officers are able to fulfill their duties to maintain the balance of keeping the youths and the community safe while understanding that, many times, a youth’s consistent challenges with following rules may be due to an unmet need rather than defiance or intentional refusal. Having an understanding of mental health needs and developmental disabilities allows them to see the need for increasing services or changing the treatment plan, rather than just detaining a youth for a violation of probation conditions. The JMHC probation officers are also able to spend more time with the youths and work to guide them toward positive interactions with their community, schools, and families.

The psychologist and psychiatrist share the role of interviewing the youths and their families when they come into the court. The interview aims to gather enough information for a thorough presentation to the JMHC team members and to support a discussion of whether the youth meets criteria for service by the JMHC. This interview is supplemented by a summary of pertinent information gained in a complete file review by the psychologist. In reviewing the court files, the psychologist is able to glean insight into symptoms and red flags that are both explicitly and implicitly noted. This information provides the basis for some of the interview questions and an opportunity to clarify and verify information in the file. The JMHC psychologist and psychiatrist also act as liaisons to the treating psychiatrists and psychologists in the juvenile halls or in the community. They are available to provide consultation regarding the youths’ mental health needs to the court. Resolving the youths’ mental health issues and supporting them in engaging in effective treatments are essential features of the JMHC team.
By integrating an education specialist into the team, the JMHC is able to support the youths and their families in accessing needed educational support through the school systems. The education liaison supports the families and youths with school enrollment, understanding of the laws supporting foster youths’ access to education as well as their educational options, advocating for youths’ needs via the education and special education systems, and facilitating communication and coordination among multiple entities (schools, districts, mental health providers, developmental services providers, etc.). Much of the education specialist’s work involves supporting families in accessing and improving the youth’s special education services through an individualized education program (IEP). Previously unidentified or unaddressed learning disabilities can significantly affect a youth’s self-esteem and school attendance, as well as underscore the need for presenting information in a way the youth can comprehend. For youths with severe needs that significantly affect their educational progress, more restrictive services such as residential placements can be obtained to address the youths’ mental health, educational, and safety needs all within one facility. At the same time, the education specialist is always working to support the least restrictive educational setting for youths while balancing their need for integrated mental health support, often on the school campus. When the educational needs of the youth are effectively met, it has a positive effect on the rest of the youth’s case and often on his or her ability to follow through with probation and court orders.

The JMHC’s defense attorney is dedicated solely to the cases supervised by this court. She, and an alternate defense attorney, work both to safeguard the youth’s legal rights and to collaborate with the team to facilitate the provision of additional supports and services to the youth and his or her family in an effort to ensure the youth’s underlying needs are met. Having an understanding of developmental disabilities and mental health needs allows the youth’s attorney to argue the validity of addressing the youth’s primary needs in order to subsequently reduce the unlawful behaviors.

Having a psychiatric social worker supporting the defense attorney brings additional expertise to the team. Connecting the families with resources, identifying additional needs or changes in the youth’s mental health needs over time, and supporting the attorney with outreach to the youth’s family and service providers improve the team’s ability to address the varied and complex needs of the youth as well as the family’s ability to navigate services and systems.

The prosecuting attorney is also a member of the JMHC team. While traditional settings often end up with the prosecuting attorney and defense attorney working against one another, in the JMHC there is much more collaboration. The prosecuting attorney still represents the people and the needs of the community for safety, while simultaneously taking into consideration how the developmental disability or mental health needs manifest in the youth’s presentation and
behaviors. Understanding the need for treatment, the prosecuting attorney works to balance public safety with the need to ensure that the youth’s underlying needs are met.

In the early years of the court, the psychiatrist, psychologist, and education liaison were county entities; however, because of the nature of their roles, conflicts of interest became apparent, and over time these three roles have transitioned to private entities. This allows for more flexibility within the role and more effective advocacy for the youths’ needs.

In addition to the individual roles of the team members, through the collaborative efforts of the team, the JMHC is able to bring a more holistic view of the youth into perspective. This unique perspective influences the creation of the treatment program.

The Process
All of the JMHC’s cases are referred post-adjudication or after a finding of incompetence. The court’s purview is to provide an alternative to traditional sentencing by creating an individualized program of supports and services that will address the primary issues that have led to the secondary behaviors and involvement with the law. Cases are referred solely by the defense attorney from any juvenile delinquency court within Los Angeles County and are reviewed individually to determine need.

The JMHC’s process begins with a thorough review of the legal file and a written summary of pertinent issues and needs, including the youth’s mental health diagnoses, symptoms, prior treatment, any child abuse or trauma experienced, prenatal exposure history, the youth’s current school and whether the youth has an IEP, the facts and charges of the case at hand and any prior cases, and other pertinent information.

The psychologist or psychiatrist—along with the defense attorney, psychiatric social worker, and if needed, the education specialist—will meet with the youth and then with the youth’s family for interviews. The interviews are designed to secure a better understanding of the mental health, developmental, and educational needs of the youth as well as to gain more knowledge about how these factors may have contributed to the current charges.

After the team has reviewed the case summary, the psychologist or psychiatrist presents the pertinent findings of the interviews to the JMHC team, and the entire team participates in a discussion regarding the appropriateness of this youth for the JMHC. The following are among the factors considered:

- Can the JMHC team provide anything more than what has already been tried?
• Are both the youth and his or her family willing to participate in the JMHC program?

• Are the youth’s mental health needs severe enough to require the unique structure of the JMHC?

The team considers not only the above questions but also how to keep the youth and the community safe and what services would need to be put in place in order to meet this objective. Because the JMHC is a voluntary court, families must agree and be willing to participate. At times, additional information is requested in order to further explore the youth’s needs and ensure the team has a solid understanding of how best to approach the youth’s service plan.

If the JMHC cannot effectively serve the youth, the case goes back to the referring court, along with recommendations. Those cases that are accepted to the JMHC (and even those temporarily supervised by the JMHC while further information is gathered) have immediate access to the resources and knowledge of the entire JMHC team. Collaboratively, the team negotiates the most appropriate and least restrictive placement options that will meet the needs of the youth while keeping the community safe, and simultaneously begins working on engaging additional community services to enable the family to have the support needed to assist the youth in complying with the court-ordered requirements.

Collaboration with additional entities is an essential component of the JMHC. Wraparound, Full Service Partnership (FSP), mental health services, Regional Center services (California’s program for addressing the needs of developmentally disabled persons), schools, local education agencies, and community-based placements are all regularly accessed to provide services to the youths and families served by the JMHC. There are sometimes significant differences in service availability, such as those within juvenile hall versus in the community, variability in supports available within the home setting versus a residential placement made a part of probation, or occasionally via the school district through the IEP process, as well as differing services and sometimes differing quality of, and access to, services in various locations throughout the county. Because the needs of the youths change as their situation and service options change, the JMHC team is consistently monitoring each youth’s progress and making adjustments to the program as needed. Having the unique perspectives of each of the disciplines involved in supporting the JMHC youth allows the team to identify needs early and work to secure services promptly.

A unique feature of the JMHC is that most charges are dismissed and available for sealing when the youth completes the treatment program successfully.
The Need
The JMHC was designed to serve 30 to 35 youths each year, though at times it has served as many as 90, and it reviews 2 to 4 new cases per week. Youths are seen frequently and typically create relationships with the JMHC team that nurture their progress and their self-esteem. Having a team that understands a youth’s needs and supports the youth’s efforts for change in tangible ways decreases the youth’s likelihood of recidivism.

Because of the severity and complexity of many of the youth’s needs, as well as the need to be able to respond efficiently to issues that shift as the youth’s treatment program progresses, it is essential to have the perspectives and expertise of all of the members of the multidisciplinary team. Without each of these professionals working collaboratively, the youth’s needs would go unmet.

While efforts are being made to reduce detention rates for youths in California, without substantial changes to the way mental health and other developmental and learning needs are addressed, it is likely that those detained will continue to be disproportionately youths with significant mental health needs. These are the youths who have typically fallen through every crack in every system and who are now involved with the law as well. Participation in the JMHC provides youths and families an opportunity to access specific and comprehensive services that target the underlying needs rather than focusing on the charges alone. Having an entire team that understands mental health needs and is able to support those needs collaboratively can change the long-term outcome for youths coming through the juvenile justice system.

Kelly Rain Collin is an educational consultant and advocate with Healthy Minds Consulting and has served as the education liaison to the Los Angeles Juvenile Mental Health Court since 2006.
Youth Access to Mental Health Services Is an Un-Prioritized Civil Right

By Victor M. Jones – December 4, 2019

For these are all our children, we will all profit by or pay for what they become.
—James Baldwin

Notwithstanding the litanies of news stories and academic journals acknowledging that the United States is, and has long been, in a mental health crisis, there still exists a mental health stigma in this country. In large part, the literature on access to mental health treatment focuses largely on adults, and not nearly enough on our nation’s children and youth (persons under the age of 21). This lack of attention to the mental health of our nation’s youth ensures that the stigma and the consequences of lack of treatment will continue.

According to the American Psychological Association (APA), nationally up to 20 percent (about 15 million) of America’s youth have a mental or emotional illness. Of those youth, only 20 percent receive any mental health treatment, and of those who do receive mental health treatment, only 7 percent receive appropriate treatment; that is, receiving a continuum of home mental health services and supports, provided by the appropriate behavioral health provider, in the least-restrictive environment (at home and in the community), at the frequency, duration, and intensity needed to address a mental illness or condition. Attention deficit/hyperactivity disorder (ADHD), behavior problems, anxiety, and depression are the most commonly diagnosed mental conditions in youth.

Despite the rising numbers of youth being diagnosed with mental illnesses, there still remains an issue with accessing mental health services to address their conditions. The APA concluded in 2009 that the youth “most in need or at highest risk are least likely to have access to the highest quality [mental health] interventions.” Thirty-one percent of white youth receive mental health services, compared with 13 percent of youth of color. See J.S. Ringel & R. Sturm, “National estimates of mental health utilization and expenditures for children in 1998.” 28 J. Behav. Health Serv. Res., no. 3, Aug. 2001, at 319–33. Lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth additionally struggle with accessing mental health services, despite 60 percent of LGBTQ youth reporting to the Centers for Disease Control and Prevention that they experience feelings of depression and anxiety. That percentage, of course, is even higher when considering the unaccounted-for LGBTQ youth who are so burdened by their existence that they are too afraid to speak on it.
When left untreated, or not timely treated, mental health issues may contribute to learning difficulties, behavioral issues, and strained family, peer, and social relationships, and lead to juvenile justice involvement and, later, unemployment or underemployment. Individuals with mental health conditions have an increased risk of chronic medical conditions and a life expectancy that is 25 years shorter than that of persons who do not have a mental health condition. Tragically, “a recent study in the *Journal of Community Health* showed that suicide rates among black girls ages 13–19 nearly doubled from 2001 to 2017. For black boys in the same age group, over the same period, rates rose 60 percent.”

For the most vulnerable populations in the country, Medicaid-eligible youth, access to a comprehensive public behavioral health system is mandated by federal law. A state’s failure to provide Medicaid-eligible youth with the necessary home- and community-based services to address their mental health needs, on a consistent and statewide basis, violates the Early and Period Screening, Diagnostic, and Treatment (EPSDT) provisions and the Reasonable Promptness provisions of Title XIX of the Social Security Act (Medicaid Act), 42 U.S.C. § 1396 et seq. The resulting unnecessary psychiatric institutionalization of these youth, or the serious risk thereof, violates Title II of the Americans with Disabilities Act, section 504 of the Rehabilitation Act of 1973, and their implementing regulations.

Through the Medicaid Act and Title II and section 504, mental health advocates have filed class action lawsuits in states—among them California, Washington, Illinois, and Massachusetts—challenging the state’s inability to ensure the provision of home- and community-based mental health services to child Medicaid populations. Just recently, on November 7, the Southern Poverty Law Center filed suit against Louisiana, alleging that the state has failed to provide intensive home- and community-based mental health services to over 47,500 Louisiana Medicaid-eligible children and youth who have been diagnosed with a mental illness or condition.

My professional experiences have shaped my beliefs about the needs for mental health services for youth and created demonstrative evidence that, had those services been rendered, we would have more just outcomes. As a children’s rights attorney, I have been afforded a front-row seat to the school-to-prison and school-to-institution pipelines in real time. So many of the clients whom I serve are subjected to exclusionary disciplinary practices or encounter the juvenile justice system (or both), while having untreated or undertreated behavioral health issues. During my time as a public school kindergarten teacher, I realized early on that it was more effective to serve the role of a counselor for my students, rather than that of a disciplinarian. I reflect on the need for mental health services in my own self: It would have been great to have someone to talk through the struggles of being a black boy growing up in the Deep South (in Mississippi), who was raised by a single mother with very limited financial
resources and who was chronically regarded as a behavioral problem by his nearly all white school teachers. As a nation with immense resources, we owe it not only to our youth but also to ourselves as an investment in the future of this country to prioritize mental health services as a civil right.

Children deserve the dignity of receiving quality mental health services that allow them to lead healthy and productive lives in their homes and communities. Access to mental health services for youth, therefore, is a civil right and should be treated as such.

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PRACTICE POINTS

Five Things to Consider When Dealing with Interstate Placement of Children

By Jonathan D. Conant – November 11, 2019

Regardless of your role in a child welfare or private adoption case, knowing these five aspects of the Interstate Compact on the Placement of Children (ICPC) can keep you out of hot water and prevent the unnecessary return of the child to the jurisdiction of the originating state. (Yes, I said return!)

1. Know Whether the Compact Applies to Your Situation
This is the first and, at times, the most difficult aspect of an interstate placement or adoption. Guidance should absolutely be sought from the ICPC Articles (primarily article VIII) and Regulations (primarily regulations 2, 9, and 12). Generally speaking if a state agency, charitable organization, or private adoption agency is seeking to send a child to another state for the purpose of fostering or adoption, the compact will apply. The compact does not apply to situations where an adult family member of no more than the third line of consanguinity (parents, grandparents, brothers and sisters, aunts and uncles) or non-agency guardians who have the legal authority to do so, seek to place the child in another state with a family member of the child with a relationship of no more than the third line of consanguinity or a non-agency guardian. If a state agency is seeking to place the child, the compact will always apply unless the state seeks to place the child with a non-offending parent under three specific guidelines: (1) the court with jurisdiction has no evidence that the parent is unfit, (2) the court does not seek evidence as to the parent’s fitness, and (3) the court relinquishes jurisdiction over the child immediately upon placement.

2. Know What Documents Are Required
Each and every action under the ICPC—an initial placement, relocation of a placement, and a request to change the placement from foster to adoption—all require an official request and response. A request for action under the ICPC is initiated by the filing of an ICPC Form 100(A). The sending party identifies the child, the sending agency or individual contact information, who the placements are, the type of action requested, and other basic information. No action may take place unless and until the receiving state indicates that the placement may be made by signing and returning the Form 100(A) indicating that the placement may be made. Once an action takes place and the child is in a placement or has been adopted, the sending state must send a completed Form 100(B), which “closes” the action under the ICPC.
Before a state will accept or reject a child, a thorough investigation will take place. Both the case history and the medical history of the child is shared. The placement is fully investigated under the receiving state’s statutory requirements, which will likely include the completion of a home and/or social study. For an agency placement, the documentation requirements are set out in regulation 2.5(a) through (j). For a private adoption, the documents required are set out in regulation 12.5(a)(1) through (16).

Of most importance, know what the individual state that you are dealing with have as their prerequisites and qualifications for a placement. Each state is different. Some will require that a placement be a licensed foster, some states do not. Some states do not require direct family members to be licensed or certified, while others do. For information on each state’s requirements, check the ICPC state pages located here.

3. Know the Players and Your Position in an Application
The administrator of an individual state’s ICPC office will usually be employed in or through the state’s child welfare agency. The ICPC administrator will deal with the other state’s administrator and communicate aspects of an ICPC application. Under the compact administrator, you will find deputy administrators who are charged with the responsibility of actually processing the ICPC applications. They will engage the services of other parties and agencies to conduct the appropriate studies. In the sending state, you will find that the ICPC application generally begins by the child welfare worker who oversees the child’s case requesting that its own state administrator file an ICPC application. The sending state administrator sends the receiving state administrator a completed Form 100(A), and the process beings.

As such, dealing with an ICPC worker is like dealing with any child welfare agency worker: you don’t! They are represented by their own legal departments and possibly the state’s attorney general’s office. Unless you are representing parties in a private placement or private agency assisted adoption, respect the rules of representation and reach out to the appropriate legal representative, rather than to the individual worker.

In a private adoption situation, you may reach out to the receiving state administrator as you will have to complete and process that Form 100(A). However, you may only deal with the administrator and rely upon that person for updates and information unless otherwise directed.
4. Know What Changes Are on the Table, and What YOU Can Do About It

The ICPC is always under consideration for improvement. Right now, there are two main initiatives that will improve the processing of applications.

The “New” ICPC

Maybe not so “new” anymore, there is a revised ICPC that was created to present a new legal framework that would provide for:

- timely placements across state lines;
- suitability of prospective family placements/resources;
- provision of needed support services;
- narrowing the applicability of the compact to the interstate placement of children in the foster care system and interstate adoptions;
- requiring the development of time frames for the completion of the approval process;
- establishing clear rulemaking authority;
- providing enforcement mechanisms;
- clarifying state responsibility; and
- ensuring a state’s ability to purchase home studies for licensed agencies in order to expedite the process.

Of most importance perhaps would be the ability to appeal a decision denying placement through a state’s administrative rules. Right now, there is no appellate right or remedy available for a denial, other than to request a review or submit a new ICPC request.

The “new” ICPC came into existence in 2006. It requires 35 states to pass laws adopting it before it becomes effective. At the current time, only 11 states have enacted it, one state has introduced it, and one state has taken a partial vote to adopt and enact it. We as lawyers can help by reaching out to our legislators to get this back on the table. During 2006, this country and our legislators were pre-occupied with a troubled
economy, but now is a good time to focus on child welfare and actually save our states money through the adoption of the “new” ICPC. You can find all the information that you need, including proposed legislative language and talking points, here.

**The Institution of NEICE**

The National Electronic Interstate Compact Enterprise (NEICE) is a national electronic system designed to quickly and securely exchange data and documents required by the compact. This was undertaken under the authority and in response to H.R. 4472 enacted by Congress on April 4, 2016, which amended the Social Security Act to require states to adopt a centralized electronic system to help expedite the placement of children across state lines. The biggest single benefit to using NEICE is the expediency at which a request and placement can take place. By means of the electronic sharing of data and information, it is possible for all the stakeholders to know what is being done, what needs to be done, and where in the process an application is at any time.

What makes this most intriguing is that each state’s compact administrator will be able to assign permissions to access files. There has recently been developed a “Review Only” module in NEICE for “judicial partners,” but access is regulated in each jurisdiction by the state compact administrator. As counsel for a party or the placement, it is imperative that you lobby your state’s compact administrator for access to files in your specific cases. In this manner you will be able to see what has not yet been done or where the case has stalled which will help you advocate more effectively.

Currently there are approximately 19 states actively using NEICE (in addition to LA County, California), 13 states are transitioning to the NEICE platform, and 11 more states are in the process of initiating the procedures necessary to adopt NEICE. Only 10 states remain currently undecided on whether to join, despite the requirement of HR 4472. Experiential data has shown that placement times have been reduced to 46 business days when both states are using the platform.

For more information on NEICE, see here.

**5. Know What Information Is Available and Where to Find It**

The ICPC is administered by the Association of Administrators of the ICPC (AAICPC). This group is affiliated with the American Public Human Services Association (APHSA). Of most importance, the AAICPC maintains a page on resources, which includes all documents which are involved in the administration of the ICPC, including information on individual states. On the resource page, you will find links to the state resources pages, along with a page for California, Colorado, and Ohio—“decentralized” states. These three states are administered on
a county by county basis as opposed to having a central location within the state as the other jurisdictions employ.

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Five Tips for Lawyers to Talk to Clients about Safety

By Jacob B. Carmi – October 22, 2019

Safety for our child clients is critical, yet lawyers do not always make it a priority to regularly ask their clients if they are safe. Regardless of where our clients are placed—whether at home, kinship care, foster care, a group home, detention, or somewhere else—we must consistently ask our clients if they are safe. Safety is something that a lawyer with lawyer-client confidentiality is uniquely qualified to address. To help you talk to your clients about safety, here are five tips to keep in mind:

1. Build a relationship and rapport with your client so that he or she trusts you enough to be truthful with you.
2. Make sure that you are speaking to your client in an understandable way and using words that make sense to your client.
3. Talk to your client about safety when you are alone with them so that they can speak freely without feeling pressure from anyone.
4. Talk to your client generally about safety. Where can your client be safe? Who helps your client feel safe?
5. Be ready to act to ensure your client’s safety, if your client wants you to act. A lawyer with lawyer-client confidentiality is in a unique position to receive information from a client about safety and to then counsel the client about options that could ensure safety. Keep in mind that some options that you talk through might be ways to ensure safety while not revealing your client as the source of the information. Note that if the young person wants you to act and you do not, you will lose the trust of your client. Alternatively, if your client is not ready for you to act, you must keep the information confidential, within the guidelines of the ABA Model Rules.

For more information see:

- Five Tips for Successfully Interviewing Your Child Client
- Counseling Children and Youth in Times of Crisis: Tips to Achieve Success and Avoid Pitfalls—Found toward bottom of the page

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