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ABSTRACT. Pediatricians recognize that social and nonmedical factors influence child health and that there are many government programs and laws designed to provide for children's basic needs. However, gaps in implementation result in denials of services, leading to preventable poor health outcomes. Physician advocacy in these arenas is often limited by lack of knowledge, experience, and resources to intervene. The incorporation of on-site lawyers into the health care team facilitates the provision of crucial legal services to vulnerable families. Although social workers and case managers play a critical role in assessing family stability and finding appropriate resources for families, lawyers are trained to identify violations of rights and to take the appropriate legal steps to hold agencies, landlords, schools, and others accountable on behalf of families. The incorporation of lawyers in the clinical setting originated at an urban academic medical center and is being replicated at >30 sites across the country. Lawyers can help enhance a culture of advocacy in pediatrics by providing direct legal assistance and case consultation for providers, as well as jointly addressing systemic issues affecting children and families. Until laws to promote health and safety are consistently applied and enforced, pediatricians will need lawyers to effectively care for vulnerable children. ***Pediatrics*** **2004;114:224–228;** ***advocacy, health disparities, prevention.***

ABBREVIATIONS. FAP, Family Advocacy Program; BMC, Boston Medical Center.

A 6-year-old boy suffered from uncontrolled asthma despite receiving daily oral doses of corticosteroids and was often absent from school, threatening his mother's ability to keep her job. During a home visit, the visiting nurse discovered mold, which was attributable to a leaky water pipe, and wall-to-wall carpeting, which harbored dust mites. The patient's mother, the nurse, and the physician all repeatedly asked the landlord to fix the pipe, clean up the mold, and remove the carpeting, with no response.

The help this child needed was beyond the reach of the primary care doctor and the asthma specialist. A new specialist was consulted and, within 6 weeks, the child had discontinued corticosteroid treatment and was attending school regularly. The specialist was a lawyer who was a member of the health care team. The lawyer researched the local and state sanitary and housing code regulations, called the landlord to inform him of his obligations to fix the pipe, clean up the mold, and remove the carpeting, and informed the landlord that the family would seek redress in court if he did not comply. The landlord immediately rectified the problems, leading to great improvement of the child's symptoms. In this article, we review the rationale for involving lawyers in children's health care, describe a prototypical model of practice, address barriers to its use, and discuss future funding and research challenges.

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RATIONALE FOR LAWYERS IN CLINICAL SETTINGS

Child health is inherently dependent on the social well-being of the family. Social and nonmedical factors influence the development of childhood disease and the severity of disease once it develops.[1–5] Public health and social policies are the traditional tools available to address nonmedical antecedents of child health problems. The Ottawa Charter for Health Promotion, sponsored by the World Health Organization, codifies specific fundamental needs for children, including peace, shelter, education, food, income, social justice, and equity.[6] There are many government programs and laws designed to meet these basic needs for low-income families, including nutrition supplementation through the Supplemental Nutrition Program for Women, Infants, and Children or food stamp programs, housing subsidies, utility assistance, income supports for disabled and low-income families, regular and special education services, and health insurance.

Many child health conditions can be traced to social factors that are potentially remediable with enforcement of existing laws and regulations. Despite this, gaps in the implementation of available programs, policies, and regulations are well documented.[7–9] Inconsistent program implementation, coupled with excessively bureaucratic administration, too often results in illegal denials of benefits and services, leading to preventable poor health outcomes. Disregard of regulations intended to protect against unhealthy environments can have similar effects. We know that asthma episodes among vulnerable children can be triggered by factors in the environment, such as air quality[10] and housing conditions.[11] Many low-income children experience impaired growth in winter because of a lack of available financial supports (known as the "heat or eat" phenomenon) although they are eligible for fuel assis-

tance.[12–14] Families who are victims of domestic violence can avoid prolonged homelessness by using housing subsidies, thus avoiding worse developmental and mental health outcomes.[15–17] Inadequate or inappropriate school services can contribute to school failure for children with learning or behavior problems.[18,19] Problems in school lead to the development of poor health behaviors[20] and poor health among adults.[21] Access to food stamps, the Supplemental Nutrition Program for Women, Infants, and Children, housing subsidies, health insurance, appropriate education, and safe homes is integral to keeping children healthy. Many factors influence a family's ability to access these programs and supports. More than one-half of all low- and moderate-income households face serious civil legal issues, although they might not recognize certain stressors, or barriers to supports, as legal issues that require legal assistance.[22] Lawyers represent the best resource for families to ensure that laws designed to promote health and safety are enforced, allowing families to meet the basic needs of their children.

Although doctors' advocacy regarding these issues is important, it has limits. Doctors and other members of the health care team generally do not understand housing codes or the intricacies of food stamp or Medicaid eligibility. Pediatricians' training and experience are generally limited to addressing primarily the biologic causes of illness. Although pediatricians are usually taught to consider family and social contexts for their patients, they often do not have the specific knowledge or resources to intervene effectively in these areas. As a result, they may be reticent to ask families about income supports, housing conditions, or access to adequate food supplies because they are unsure what to do with the responses. Although some physicians become experts in certain areas, most physicians who inquire about these topics experience significant frustration when they try to intervene, because social problems are daunting.

Traditionally, health care providers have turned to social workers and case managers to assist families with basic social needs. Social workers and case managers are the front-line experts in assessing family stability and finding appropriate community resources for low-income families. They are critical members of the health care team. However, even social workers and case managers sometimes have difficulty convincing programs to provide services to families or effectively addressing intended or unintended barriers to accessing social services. Social workers and case managers now can turn to lawyers trained to address exactly these types of problems. Ideally, lawyers, as advocacy experts, can train doctors, nurses, and social work staff members to be more effective advocates and can act as backup resource providers if an impasse in accessing programs or financial supports is reached. Although generalists can screen for and address many problems, such as a heart murmur or blood in the urine, they turn to specialists in cardiology or nephrology when the problem cannot be resolved easily or is more complicated. Similarly, lawyers can provide "specialized treatment" for rights violations and can take the appropriate legal steps to hold agencies, landlords, schools, and others accountable on behalf of families.

MODELS OF PRACTICE

Although every community has some sort of civil legal aid services for indigent individuals and families, publicly funded legal service programs serve only a small proportion of legal needs for low-income families, because of limited resources and client restrictions based on immigration status and income.[22] For working families with young children, obtaining access to legal services can be extremely challenging, because of difficulties with costs, childcare, and transportation. Moreover, many parents do not recognize their problems as legal issues.

An increasing number of pediatric programs serving poor and low-income families are integrating lawyers into clinical settings, including that at Boston Medical Center (BMC), which began with 1 lawyer >10 years ago.[23] At BMC, the Family Advocacy Program (FAP) is now staffed by 4 on-site lawyers and an outreach coordinator. The FAP also relies on the efforts of 8 to 10 students and volunteers, as well as significant pro bono support from private law firms, and works in partnership with local legal aid offices.

The FAP conducts 4 weekly legal clinics, at BMC (including referrals from primary care and subspecialty clinics, inpatient services, and the emergency department) and 3 community health centers. FAP staff members are available for case consultations with pediatricians, nurses, social workers, and case managers. In 2002, the FAP addressed the needs of >700 families, in the areas of housing, immigration, income supports, disability, health insurance, family law, and education access. FAP staff members spend up to 25 hours on 25% of all cases, 25 to 50 hours on 50% of all cases, and 50 to 200 hours on the remaining 25% of all cases. The FAP is successful in achieving the desired benefit or result in the majority (~65%) of cases.

The FAP model is being replicated at >30 clinical sites across the country. The principle goal of all of the programs is to ensure that families have their basic needs met, by providing them with access to legal assistance when they might not have had it otherwise. Any clinical practice serving low-income families, from the smallest community health centers to major tertiary-care facilities, can incorporate legal assistance at some level. Indeed, special populations served at large hospitals and academic medical centers, such as neonatal intensive care unit or asthma patients, may present unique opportunities for advocacy interventions. Project Access, a partnership among Mt. Sinai Hospital Medical Center, University of Chicago Children's Hospital, and Health and Disability Advocates, focuses on such a population. Low-income families with children with special health needs such as asthma often experience significant loss of income, because the child's illness may prohibit full-time employment, and thus are particularly reliant on benefit programs. These families are especially well suited to legal advocacy services provided in clinical settings that focus on income max-

imization, disability determination, and special education services.

The presence of on-site legal services not only removes traditional barriers to obtaining legal assistance but also increases the likelihood that families will receive the information and assistance they need before a deprivation of rights leads to a crisis, such as child abuse, homelessness, or parental job loss. An interdisciplinary approach to child health is not new. In fact, child health programs have a long tradition of bringing workers in diverse disciplines, such as nurses, psychologists, health educators, nutritionists, and social workers, together in clinical settings.[24] Lawyers represent a natural extension of this approach. There are several ways to incorporate lawyers effectively into pediatric practices, as illustrated in the following scenarios.

DIRECT LEGAL ASSISTANCE FOR FAMILIES: THE SUBSPECIALIST

Lawyers can be available as subspecialists to provide very specific consultations regarding difficult problems. For example, Helen lost her job after multiple absences to care for her child, who has sickle cell anemia, and was behind in her rent payments. Referred by her child's pediatrician, Helen contacted the lawyer in the pediatric clinic when she received an eviction notice. The lawyer determined that Helen was eligible for state rental assistance and spoke with Helen's landlord on her behalf. Helen received the rental assistance and was not evicted. The attorney also helped Helen apply for food stamps, Temporary Assistance for Needy Families, and Supplemental Security Income, so that she could support her family more effectively.

CASE CONSULTATION FOR PROVIDERS: LAWYERS AS PART OF THE TREATMENT TEAM

Lawyers can provide an excellent adjunct to primary care. They can partner with pediatricians, nurses, or other health care professionals in screening families for social problems, by being available for walk-in consultations and integrating social work support. One example of how lawyers can function in this role is the situation of Maria, who has 3 children. The youngest child is 14 months of age, was recently diagnosed as having failure to thrive syndrome, and was prescribed an expensive formula supplement. When Maria's health insurance rejected her claim for coverage, the FAP attorney assisted the pediatrician in drafting a successful appeal letter and Maria began receiving the supplement free of charge. Attorneys at BMC play a critical role in training providers, residents, and others to write effective advocacy letters (a skill that is not taught in medical schools), thus developing clinician experts in advocacy.

By seeing families in a child health clinical setting, lawyers not only contribute to the preventive efforts of pediatricians but also can introduce the practice of "preventive law," because they see families before a lack of receipt of public benefits or illegal practices lead to crises. For many families with chronically ill children, for example, a child's illness can lead to job loss because of recurrent episodes of illness and/or doctor appointments.[25] Without income, families stop paying their utility bills, which results in utility disconnections, the development of health hazards in the home, and possible eviction and homelessness. Lawyers can disrupt this sequence by supporting social workers' efforts to help families access appropriate income supports, such as unemployment insurance, Temporary Assistance for Needy Families, and Supplemental Security Income, and by working with utility companies to prevent disconnections. Although utility companies often ask health care providers to verify that a low-income family needs utility services that have been discontinued, providers and social workers may not have the time or training to understand the nuances of the law or to learn the detailed processes for each utility company. For example, in Massachusetts, utility companies will not discontinue utility service, in most cases, as long as some type of monthly payment is made.

SYSTEMIC REFORM: MEDICAL-LEGAL PARTNERSHIPS PROMOTING SYSTEMIC CHANGE

Lawyers can focus on legal advocacy regarding systemic issues facing many families in a pediatric practice. For example, in 1999 a BMC advocacy attorney began to investigate why multiple families were being refused exemptions from welfare-to-work requirements despite having chronically ill children. The Massachusetts Department of Transitional Assistance, using strict Supplemental Security Income disability criteria not intended for such a purpose, had raised the standard by which families of disabled children would be eligible for welfare program work requirement exemptions. FAP attorneys brought a patient's family and pediatricians into a class action suit, in collaboration with local legal service providers. As a result of the combined advocacy of pediatricians and lawyers, the court entered an injunction overturning the illegal regulation.

BARRIERS TO INCORPORATING LAWYERS INTO THE CARE TEAM

Although there is a compelling rationale for including lawyers in the child health care team, there are clearly important challenges to be overcome, including funding, potential overlap in roles, and patient resistance. These challenges are not insurmountable, however.

Obviously, funding can be a barrier to creating a health care team that includes lawyers. Legal aid services are not reimbursable by insurance; however, Medicaid reimbursement may be possible, because many of the tasks are similar to those of reimbursable case management and Medicaid does not stipulate that lawyers may not perform case management. Although it would not cover the complete costs of such services, Medicaid reimbursement has the potential to fund programs partially, with other sources being used to complete funding. At BMC, foundations, corporate (including law firm) sponsors, individual philanthropists, and bar associations have stepped forward to fund the FAP. They recognize the implications for creating better accountability of state

and federal systems and for reengineering community-based services for families with young children through this innovative collaboration. At BMC, lawyers are paid at the legal aid scale, which is dramatically lower than private-sector rates. FAP staff members leverage resources by providing an internship experience for students who receive academic credit for staffing legal clinics. Other sites have used a "no new cost" strategy, which involves collaboration with local legal aid programs providing outreach legal services in pediatric settings. Although this does not provide a net gain of services in the community, the development of doctor-lawyer collaborations is regarded by many legal aid specialists as an opportunity to be more effective and to develop a new constituency for their services; pediatricians and their patients appreciate the help. The FAP and other sites have also established relationships with local private-sector law firms, which provide pro bono services to pediatric families in need.

Another potential barrier involves unclear delineation of roles among the health care team. There is a potential for friction between team members if roles are not specifically outlined in a manner that highlights the unique expertise of each member. Although an interdisciplinary approach to children's health is not new, traditionally social workers and case managers have been charged with addressing the social context of children's needs.

Although social workers are more familiar than doctors or nurses with many of the access and resource issues that low-income families face, they may not be knowledgeable about the changing laws and regulations that affect family eligibility for benefits and services. This has become an increasing problem in the past 20 years, because the emphasis of social programs has shifted from helping families in need to preventing fraud. Regulations to ensure that only families that meet specific need criteria receive assistance have resulted in barriers that prevent some families from receiving benefits to which they are entitled legally. Like other subspecialists, lawyers provide consultation and training for the health care team, including social workers. When lawyers, who recognize these breaches of law, work together with doctors, nurses, and social workers, the team practices effective preventive medicine by ensuring access to basic family and social needs.

A related barrier to incorporating lawyers in clinical settings is the perception, on the part of hospital or legal aid staff members, that the collaboration poses a conflict of interest, creates an ethical dilemma, or somehow violates the patient's right to confidentiality. Although it is essential to explore and reinforce the separate obligations of each institution to the patient-family, the ethical and confidentiality issues can be resolved with a clear understanding of the role of the on-site lawyer and regular consultation with bar association guidelines devised for this purpose.[26]

Another barrier can be patient resistance to using legal services. This resistance may be attributable to several causes. Families may have had unsatisfactory experiences with legal services. More importantly, families may have concerns regarding confidentiality and disclosure of sensitive or potentially incriminating information. However, the presence of on-site legal services staffed by lawyers and student interns may help overcome these barriers by increasing the likelihood that families will receive the information and assistance they need before a deprivation of rights leads to a crisis. Moreover, the health care setting is perceived as a safe and trustworthy environment where families can receive accurate information and services regarding issues that affect their children's health and well-being.[27] With state and federal budget shortfalls, the need for such services is likely to grow.

RESEARCH CHALLENGES

Currently, the FAP tracks its progress through process evaluations and the traditional legal aid outcome measures, such as benefits granted and housing subsidies obtained. Studies need to be conducted to determine whether patients are healthier in response to interventions provided by lawyers. However, similar to the difficulty of evaluating policies that address nonmedical determinants of health, including income redistribution,[28] it will be difficult to evaluate the health effects of a program that addresses such diverse problems. A true cost-benefit analysis that includes the social and personal costs of preventable child illness, as well as the costs of missed parental work, may help justify the expenses of lawyers, although their costs only marginally exceed those of social workers. Proof of improved health after interventions for low-income, biologically vulnerable children, such as those with asthma, very low birth weight, or trauma, may be easier to demonstrate, because it is likely that a materially inadequate environment would affect their tenuous health.[5] However, it could be argued that, in a country governed by laws, adherence to laws promoting the social well-being of families or a healthy environment is as important as health outcome data. Those who require proof of health effects before supporting doctor-lawyer collaborations need to be creative in determining how to approach the challenges to ethical and realistic evaluations.

CONCLUSIONS

Addressing the social determinants of children's health is just as important as providing an immunization or a prescription. It is time to add lawyers to our multidisciplinary teams, to promote health and prevent disease. Is using lawyers too heavy-handed and litigious? We think not. In fact, by intervening early and collaboratively with clinicians, lawyers not only improve health but also often can avoid litigation, by citing existing laws and encouraging compliance.

Until laws to promote health and safety are consistently applied and enforced, pediatricians will need lawyers to effectively care for low-income children. Although we think we need lawyers to provide optimal health care to children, we hope public officials and policy-makers will be troubled enough to

ask, "Tell me again, why do pediatricians need lawyers to help them take care of their patients?"

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