PREVENTIVE LAW: INTERDISCIPLINARY LESSONS FROM MEDICAL–LEGAL PARTNERSHIP

MALLORY CURRAN∞

THE FOLLOWING IS AN EDITED AND FOOTNOTED TRANSCRIPT OF THE KEYNOTE ADDRESS OF THE 2013 REVIEW OF LAW AND SOCIAL CHANGE ANNUAL ALUMNI RECEPTION. THE LECTURE WAS DELIVERED AT NEW YORK UNIVERSITY SCHOOL OF LAW ON APRIL 17, 2013. MS. CURRAN WAS INVITED TO DELIVER THE ADDRESS IN RECOGNITION OF HER PIONEERING ROLE IN THE MEDICAL–LEGAL PARTNERSHIP MOVEMENT AND HER DEMONSTRATED COMMITMENT TO THE VALUES OF THE REVIEW OF LAW AND SOCIAL CHANGE. BY DESCRIBING REAL-LIFE STORIES OF INDIVIDUAL CLIENTS AND SUCCESSFUL ADVOCACY EFFORTS, MS. CURRAN ILLUSTRATED MEDICAL–LEGAL PARTNERSHIP'S UNIQUE ABILITY TO IMPROVE COMMUNITY HEALTH ON THE FRONT LINES OF THE DELIVERY OF HEALTHCARE AND WHERE POLICY DECISIONS IMPACTING HEALTH ARE MADE. APPLYING THE LESSONS LEARNED FROM HER CAREER TO THE BROADER PUBLIC INTEREST LAW COMMUNITY, MS. CURRAN ENCOURAGED THE AUDIENCE TO EMBRACE OPPORTUNITIES FOR INTERDISCIPLINARY PARTNERSHIP AND TO SEEK OUT OPPORTUNITIES TO PRACTICE PREVENTIVE LAW.

Fifty million Americans need legal care in order to be healthy. To address this largely unmet need, the medical–legal partnership (MLP) movement arose to bridge the gap that had existed between those in the legal and medical professions who serve the most vulnerable members of our communities. We in the MLP movement believe that the legal and medical professions must work together to overcome what are known in the medical world as social determinants of health—those social, economic, and environmental factors that influence health and cannot be resolved through access to quality medical care alone. MLP brings together the medical and legal professions to address the needs of vulnerable patients and communities by identifying, solving, and preventing health-harming legal needs.[1] In the legal world we often call this providing access to justice.

∞ Ms. Curran is the Supervising Attorney of the Mental Health Law Project at MFY Legal Services, Inc. and a member of the Advisory Council of the National Center for Medical–Legal Partnership at George Washington University. She wishes to thank Keith Romer and her clients and colleagues from Cleveland and New York City.

1. NATIONAL CENTER FOR MEDICAL–LEGAL PARTNERSHIP, THE MEDICAL–LEGAL PARTNERSHIP TOOLKIT PHASE 1: LAYING THE GROUNDWORK 2 (2014), http://www.medical-legalpartnership.org/wp-content/uploads/2014/03/MLP-Toolkit-Phase-I-FINAL-FILLABLE.pdf.

While medical–legal partnership refers to the movement as a whole, the on-the-ground work is mostly done by individual MLPs working at the local level. Each MLP has its own unique form, depending on the medical and legal organizations involved, but there are several core commonalities across different partnerships. First, an MLP will have a legal presence on-site in one or more medical settings. Attorneys and paralegals meet face-to-face with both patient-clients and healthcare staff at the hospital, clinic or community health center. Second, the legal and healthcare partners will work together to identify priorities. What types of patients will be seen by the legal staff? What types of health-harming legal needs will be the focus of the partnership? Third, there will be a high level of communication between the legal and healthcare staff, both regarding individual patient-client cases and as a means to identify and address opportunities for systemic improvements.[2]

To help better explain how MLP works, I am going to share a story with you about one of the families with whom I worked when I was part of the Community Advocacy Program, a medical–legal partnership of the Legal Aid Society of Cleveland and MetroHealth Medical Center.

A case was referred to me by a mental health social worker in the Department of Pediatrics. The case involved a middle school-aged girl I'll call Ana Maria.[3] Ana Maria had been overcome in the past weeks by a growing compulsion to seriously harm members of her family and to commit suicide. She was hospitalized in the Cleveland area at a facility that specializes in treating children experiencing mental health crises.

You may be wondering, as I was, what a lawyer can do to help in a situation like this. It turns out that Ana Maria's parents had applied for disability benefits through Social Security for her and had learned from the MetroHealth social worker that I could help them with the appeal. Ana Maria's mother explained to me over the phone that because of safety concerns she had withdrawn Ana Maria from her public school two years earlier, after Ana Maria attempted suicide following an incident of bullying. She had been home schooling Ana Maria ever since, which meant that she wasn't able to work. The family had tried to avoid applying for these financial benefits, but it was getting too hard to make ends meet. In denying Ana Maria's initial application, Social Security had indicated that Ana Maria's mental health problems were not severe enough.

---

2. *See* Elizabeth Tobin Tyler, *Introduction* to ELIZABETH TOBIN TYLER ET AL. EDS., POVERTY, HEALTH AND LAW: READINGS AND CASES FOR MEDICAL–LEGAL PARTNERSHIP xxxi, xxxii (Elizabeth Tobin Tyler, Ellen Lawton, Kathleen Conroy, Megan Sandel & Barry Zuckerman eds., Carolina Academic Press 2011); TISHRA BEESON, BRITTANY DAWN MCALLISTER & MARSHA REGENSTEIN, MAKING THE CASE FOR MEDICAL–LEGAL PARTNERSHIPS: A REVIEW OF THE EVIDENCE 2 (National Center for Medical–Legal Partnership ed., 2013), http://legalaidresearch.files.wordpress.com/2013/04/medical-legal-partnership-literature-review-february-2013.pdf. For additional background on medical–legal partnership, visit the website of the National Center for Medical–Legal Partnership at http://www.medical-legalpartnership.org.

3. All names and some identifying details have been changed to protect client privacy.

Ana Maria's parents came in to MetroHealth to talk with me and sign some paperwork so that we could get to work on the disability appeal. Given the severity of Ana Maria's history and her hospitalization, and my existing strong relationships with her healthcare providers, I was confident that we would be able to collect the documentation we needed to get her appeal approved with relative ease.

I then turned the conversation to something I thought to be equally important for Ana Maria's long-term well-being: school. When I asked Ana Maria's parents if they had ever considered having her evaluated for special education, they were really surprised that I would even suggest it. They responded that Ana Maria was extremely bright -– a straight A student.

This opening provided me an opportunity to talk about how special education is intended to assist students who have difficulty with the process of learning, but also students who have other significant disabilities which impact their school performance. As I told Ana Maria's parents, a student can both be gifted academically *and* qualify for special education services.

I told them about a school I knew of that had a rigorous academic component in addition to the mental health supports Ana Maria would need. The school was expensive, but if Ana Maria was evaluated and found to be eligible for the school's services, her school district would be required by law to send her at no cost to her parents.

Typically, a child hospitalized in northeast Ohio for mental health reasons is discharged within five days. Ana Maria stayed in the hospital for almost six weeks. While she was hospitalized, we moved forward with her disability appeal and with our request for a special education evaluation.

As expected, Ana Maria's evaluation showed her to be both above grade-level in academics and in need of special education due to her mental health problems. Her hospitalization ended in the late spring, and she began to see MetroHealth mental health providers on an outpatient basis. We were able to visit the school I had in mind for her, and she was accepted for a summer program and for the next academic year. By the following spring, Ana Maria was no longer suicidal or at risk of harming others. She was making honor roll, and she and her teachers were planning a rigorous high school schedule for her upcoming ninth grade year.

I share this story because it highlights one of the aspects that make the medical–legal partnership itself so successful: the ability of the partnership to connect patients to legal help they may have never known to seek otherwise. While medical problems clearly demand medical attention, turning to an attorney to assert legal rights that directly impact health is often not an obvious route. Ana Maria's mother would never have come to the Legal Aid Society on her own. Why would she? She never conceived that the barriers Ana Maria faced included unmet legal needs. She hadn't considered that there were attorneys who

could help with Social Security appeals. And she certainly did not identify her daughter's school-related challenges as having a legal solution.

Ana Maria's family required legal care to complement Ana Maria's mental health care. The MLP was successful in putting together the strongest possible disability appeal to stabilize the family's finances; negotiating to expedite an evaluation for special education even though Ana Maria was not currently enrolled as a student in the school district; and advocating to ensure that Ana Maria was placed in a school that could meet her unique needs. These legal solutions were all essential to helping Ana Maria overcome her crisis and succeed.

Together, Ana Maria, her family, her mental health providers, and I were able to do something I firmly believe we could not have accomplished without each other: We moved Ana Maria from suicide watch to the college track.

Since my own career trajectory in many ways parallels the evolution and expansion of the MLP movement, I will briefly outline it here. It both helps to describe a small piece of the history of the MLP movement and suggests a path for those who might be interested in joining the movement themselves.

Upon graduating from law school, I was awarded a Skadden Fellowship to start the Community Advocacy Program, a medical–legal partnership of the Legal Aid Society of Cleveland and MetroHealth Medical Center, in 2002. The Community Advocacy Program was one of the first medical–legal partnerships in the country, and for four years I was the only attorney on the project.

In 2006, the Community Advocacy Program received a grant from the Robert Wood Johnson Foundation, which was in turn matched by ten local funders from both the private and non-profit sectors. We received one million dollars over a period of four years, which we used to grow our medical–legal partnership by adding staff, extending our reach from MetroHealth's main campus to three community health centers, and expanding our patient base to include immigrants, older adults, and people with a history of incarceration.

While our MLP was expanding in Cleveland, the MLP movement was also expanding around the country. Nationwide, the movement grew from five MLPs in five medical centers in 2002 to almost 100 MLPs serving patients in almost 300 hospitals and community health centers by 2013.[4] Within the movement, we hope that over the next five to ten years, MLP will expand to serve patients in thousands of medical settings.

Today, I retain a local role in an individual MLP, and I also have a national role in the broader MLP movement. On the local level, I moved back to New York two years ago and became the supervising attorney for the Mental Health Law Project at MFY Legal Services. The Mental Health Law Project prevents homelessness, promotes employment, stabilizes income, and supports mental

4. *Join the Movement*, NATIONAL CENTER FOR MEDICAL–LEGAL PARTNERSHIP (Apr. 20, 2014, 5:13 PM), http://www.medical-legalpartnership.org/join-movement.

health recovery in partnership with hospital-based and outpatient community mental health providers, including psychiatrists, psychologists, and social workers.[5] Although MFY did not apply the moniker of MLP to the Mental Health Law Project until more recently, MFY attorneys have been vanguards of interdisciplinary collaboration, providing "legal care" to New Yorkers with mental illness for 30 years.[6]

On the national level, I served for two years as Chair of the Advisory Council to the National Center for Medical–Legal Partnership, and I remain a member of the Advisory Council.[7] I am fortunate to have the opportunity to remain engaged in MLP on both the local and national levels.

Now I want to talk about two concepts at the core of MLP that also apply to other disciplines: (1) using individual cases to inform systemic change; and (2) the practice of preventive law.

First, I will discuss how individual cases can inform efforts to engage in policy advocacy and systemic reform. Like Ana Maria, a number of children with whom I worked had school-related issues. In fact, a large percentage of the cases that were referred to the Community Advocacy Program involved special education. Far too often, we would hear from parents who had been making verbal requests to have a child evaluated for special education for months or even years without the school taking any action (other than repeatedly suspending or failing the student). As attorneys, we were especially frustrated, because there was no easy way to prove that these verbal requests had ever been made. In fact, this lack of action was happening so often that we knew we could never help every patient having this problem. We started to think about ways to increase our capacity without increasing our caseload.

In conversations with our pediatric colleagues, we found out that some of them were using the electronic medical record as an advocacy tool by creating templates to help parents put evaluation requests in writing. A simple, brilliant concept, but the truth is that a lot of pediatricians simply don't have the time to craft a polished composition. Attorneys, on the other hand, know how to write a good letter. These letters needed a lawyer's touch to make sure they said exactly what they needed to say to assert and protect patients' rights.

So, in partnership with medical providers, we created advocacy letter templates, which were loaded directly into the electronic medical record system. They were accessible to every medical provider at MetroHealth. If a pediatrician was working with a child who needed to be evaluated for special education, she could pull up the template in the computer, personalize it for her patient, and

5. *Mental Health Law Project*, MFY LEGAL SERVICES, INC., http://www.mfy.org/projects/mental-health-law-project (last visited Sept. 21, 2014).

6. Jeanette Zelhof & Sara J. Fulton, *MFY Legal Services' Mental Health-Legal Partnership* 44 CLEARINGHOUSE REV. 535, 536 (2011).

7. *Advisory Council*, NATIONAL CENTER FOR MEDICAL–LEGAL PARTNERSHIP (July 7, 2014, 10:17 PM), http://medical-legalpartnership.org/national-center/advisory-council.

print it out for the parent to take to the school. Voila! A paper trail. Soon, hundreds of letters were being downloaded and printed out each year.

And we didn't stop there. We knew that the letter represented a solution that could be used in a variety of settings to address of variety of needs. With this in mind, we created more school-related letters, and letters to send to landlords, to the welfare department, and to Social Security.[8] I am positively evangelical about these electronic medical record advocacy letters. I think they are beyond wonderful.

My husband Keith, who has heard me go on about this many, many times, reminds me that not everyone will find electronic medical record advocacy letters as exciting as I do. And I do -– I find them very, very exciting.

However, Keith suggests that to some people they might be…a little boring. And I get that. I get that, on the surface, these letters may seem like a boring solution to boring problems. But what is *not* boring is the impact that they have. What is *not* boring is that, every year, hundreds of students in the Cleveland area are able to use these letters to demand their legally guaranteed special education-related rights. And that's just Cleveland. The concept of electronic medical record advocacy letters is still just beginning to take hold across the country.

What is *not* boring—what, in fact, is so exciting to me—is that this solution works. It allows patients and doctors to stop banging their heads against the brick wall of bureaucracy. It helps people gain access to the rights to which they are legally entitled and that *change their lives*.

Here's another example of how medical–legal partnership works in action. Pictured below is the Karody Special Education Calculator, named after Dr. Vijender Karody, who did his pediatric residency at MetroHealth.[9] One day, my MLP colleague, an attorney named Lucas Caldwell-McMillan, was telling Dr. Karody about our struggles to come up with a way to clearly explain to clients the various dates and timelines relevant to the legal rights of parents and students in special education evaluation law. Dr. Karody said, "Oh! You need something like a gestational calculator."

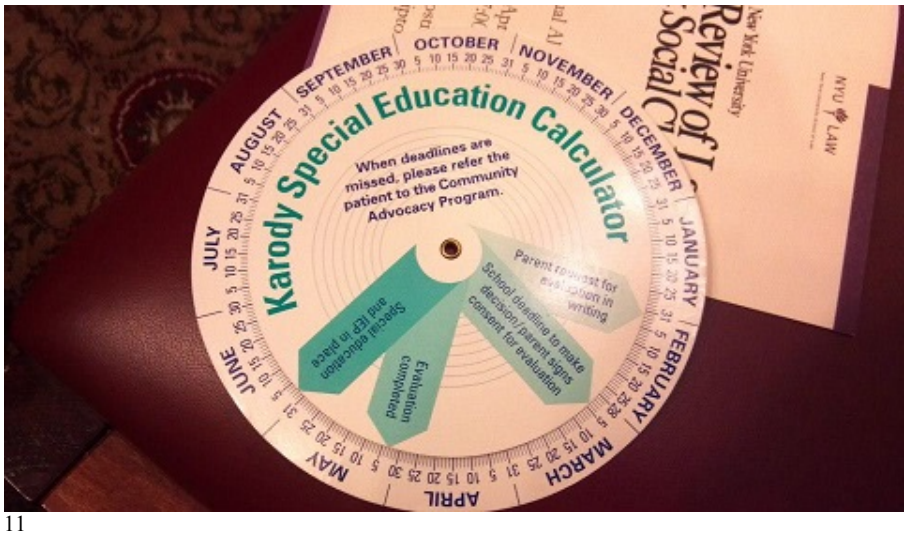
Lucas said, "Like a what?" Dr. Karody ran out to the nurse's station and brought back a gestational calculator, a dial-like tool that is used to estimate a pregnant woman's due date. And we said, "Yes! We need something exactly like a gestational calculator."

Thus, the Karody Special Education Calculator was developed. The Karody Calculator includes a date calculator on the front, and on the back it includes

8. Shelly Anarado Okere, Letter to the Editor, *Pairing Health Records with Patient Advocacy*, CLEVELAND PLAIN DEALER (Apr. 10, 2013, 3:59 AM), http://blog.cleveland.com/letters/2013/04/pairing_health_records_with_pa.html.

9. *Update on the Community Advocacy Program (CAP)*, THE LEGAL AID SOCIETY OF CLEVELAND, http://lasclev.org/update-on-the-community-advocacy-program-cap/ (last visited Sept. 21, 2014).

information about how to print out the advocacy letters from the electronic medical record.[10]



11

Now again, my excitement about these calculators may seem out of proportion to the little cardboard thing in the picture. You may be thinking, "She spent three years in law school and however many years working in the field, and some weird, circular, spinning thing is one of the most exciting developments of her career?" And I say to you: "Yes." Because again, the calculators work. They solve a problem. They clearly illustrate to both parents and medical providers what needs to be done in order to trigger legal rights under the law. They provide a step-by-step method by which parents and students can assert their own educational rights, and they provide information on how parents can link up with legal assistance when those rights are violated. When we gave the calculators to the pediatricians we worked with, they were excited as well, knowing that they were going to be able to use the calculators to help their patients access much needed services, which have a life-long impact on health.

What you may have noticed in these stories is that none of these achievements belong entirely to the lawyers. Nor, of course, do they belong entirely to the doctors, nurses, or social workers.

These advocacy letters and the calculator are wonderful examples of how in medical–legal partnership, the whole is greater than the sum of its parts. The

10. Pamela Tames et al., *Education: Connecting Health and Quality Learning Opportunities in Poverty, Health, and the Law*, in POVERTY, HEALTH AND LAW: READINGS AND CASES FOR MEDICAL–LEGAL PARTNERSHIP, *supra* note 2, at 288–89.

11. We thank Colleen M. Cotter and The Legal Aid Society of Cleveland for their permission to use this photograph.

synergy between the two fields leads to creative collaboration and innovative solutions to patient problems. You don't get the kind of cross pollination that leads to a Karody Special Education Calculator without having the doctors and the lawyers occupying the same space, tackling the same problems together.

So, now we have the doctors and lawyers working together to solve these problems relating to children's education. Who haven't we involved yet in solving these problems? The schools themselves. As much as we loved our advocacy letters and the Karody, we also realized that what would really make the most sense is for everything to be taken care of at school. It should be the easiest thing in the world for parents and guardians to go into a school, request an evaluation for special education, have someone help them put that request in writing, and receive a response to that request in a timely manner.

We set up a meeting with the Ohio Department of Education and presented them with the problem: children are waiting too long to be evaluated. We also presented them with a solution: a simple evaluation request form. The key part of the form, however, was a receipt to be signed and dated by the school and given to the parent as proof of their request. In other words, a paper trail.

After some consideration, the Department of Education indicated that it could make the form part of "resolution agreements" when complaints were filed against districts and charter schools for untimely evaluations. They then developed the form, with receipt, as a so-called model form readily available for districts across the state.

It's the simplest thing. A one-page form. Hardly rocket science. And yet, for years no one had acknowledged the problem or come up with a workable solution. These simple solutions may not warrant a front-page headline, but they can have the strongest, most effective, and longest-lasting impact on seemingly entrenched problems.

This is also a great example of how we identified a trend in our individual casework, developed systemic changes within MetroHealth to expand our capacity to advocate on behalf of patients, and then leveraged the lessons we learned to make a statewide policy improvement.

This concept of trying to resolve problems "upstream" before they turn into crises "downstream" is one that those in medicine have long embraced.[12] For years, an emphasis has been placed on preventive medicine. If you help patients maintain their health over the course of their lives, you can do far more to help them than if you only intervene once they face a health crisis. Wash your hands, eat well, wear a seatbelt—boring solutions maybe, but solutions that truly help people live longer, healthier lives. As lawyers moved into the clinical setting

12. *See, e.g.*, David R. Williams et al., *Moving Upstream: How Interventions That Address the Social Determinants of Health Can Improve Health and Reduce Disparities*, 14 J. OF PUB. HEALTH MGMT. AND PRACTICE S8, S8 (Nov. 2008); RISHI MANCHANDA, THE UPSTREAM DOCTORS: MEDICAL INNOVATORS TRACK SICKNESS TO ITS SOURCE 1–4 (TED Conferences 2013).

through MLP, our medical partners pushed us to rethink our own work, and to embrace opportunities to practice preventive law.

I'll say it again because I think the idea is so important: preventive law.

Much of public interest law is practiced in the legal equivalent of the emergency room: we are so flooded with potential clients that our triage frequently excludes those who aren't already in a legal crisis.[13] We represent tenants, but only in housing court after an eviction proceeding has begun. We represent people accused of crimes, but only after they have been formally charged. We represent homeowners, but not until they are in foreclosure proceedings. This is important work. Crucial work. But it should never be our only work.

Historically, the public interest law community has perhaps not valued preventive law as highly as it has valued crisis intervention law. But through medical–legal partnership and other movements such as community-oriented defense, the tide is starting to shift.[14]

I'll share a couple of examples of how preventive law can work.

A girl I'll call Mary was referred to me at MetroHealth. A high school student raising an infant son, she had been kicked out of her mom's house for getting pregnant and was living with her godmother, a non-relative. She was also at risk for dropping out of high school because the welfare department had denied her application for subsidized day-care vouchers because she was under 18 and living with a non-relative.

An honor roll student enrolled in a special medical training program, Mary was missing class because she couldn't pay someone to care for her son during school hours.

Mary was referred to me by her son's pediatrician in the hope that we could help prevent her dropping out of school. I had the opportunity to intervene *before* her life reached a crisis point, *before* she dropped out of school, *before* she was forced to try to raise and support her son without a high school degree. I did some legal research about the right of minors to have their own welfare case, and found a little-used catchall regulation that I thought could be made to fit her situation. I wrote an advocacy letter to the director of her local welfare center making my legal arguments and followed up with a few phone calls. Within a few days, he agreed that they could open a case for her—not just 40 hours per

13. Pamela C. Tames et al., *Medical–Legal Partnership: Evolution or Revolution*, 45 CLEARINGHOUSE REV. 124, 133–34 (2011).

14. Samantha Morton et al., *Advancing the Integrated Practice of Preventive Law and Preventive Medicine, in* PREVENTIVE LAW AND PROBLEM SOLVING: LAWYERING FOR THE FUTURE 343–364 (Thomas Barton ed., 2009). *See also* COD Advisory Group, *Ten Principles Of Community Oriented Defense*, BRENNAN CENTER FOR JUSTICE (July 7, 2014, 10:51 PM), http://www.brennancenter.org/sites/default/files/legacy/Justice/COD%20Network/CODStatementofPrinciples.pdf (including "Fix Systemic Problems" as one of the principles of Community Oriented Defense).

week worth of day-care vouchers, but also cash assistance, food stamps, and Medicaid.

Mary not only graduated from high school, but also passed her medical assistant exam with flying colors. She started working at a local hospital while attending classes at a local community college. Soon after, she began to study nursing full time at a four-year college.

Mary regularly took her son to MetroHealth for routine check-ups and vaccines: preventive medicine. By providing Mary with some routine legal work to support her educational and employment goals, we were able to provide preventive law. A college degree in nursing was the best medicine for a healthy future for Mary, and for her son.

I have been discussing the work I did while I still lived in Cleveland, and I would be remiss if I didn't include at least one story from MFY Legal Services. As the supervising attorney of the Mental Health Law Project, I rarely take on my own cases. However, I work with a number of skilled, creative, and committed attorneys doing inspiring work on behalf of New Yorkers living with mental illness.

This story highlights the work of my colleague Orier Okumakpeyi, who received a call from a clinical social worker at the VA hospital. The social worker was working with a veteran, whom I'll call Mr. Lee, who was severely depressed and could barely make it out of bed most days. Mr. Lee's family members were all living in other parts of the U.S. or in his home country, and he was experiencing significant social isolation. It turned out that Mr. Lee loved animals and wanted to have a dog. However, he lived in a no-pet building. The VA social worker wrote a letter to his landlord, asking if Mr. Lee could have a dog. "No," responded the landlord. "No pets, no exceptions." Utterly devastated by this news, Mr. Lee experienced a worsening of his depression and became at high risk for committing suicide. The VA staff members were so concerned that they completed a formal suicide prevention plan.

Desperate for assistance, Mr. Lee's psychologist contacted Orier, who educated the social worker about the magic words that could provide some relief for Mr. Lee: "reasonable accommodation request."[15] Orier explained to the social worker that under the Fair Housing Act, the landlord might be legally required to allow a dog as an accommodation to Mr. Lee's disability. Following Orier's advice, the social worker drafted a letter in support of the reasonable accommodation request, which Orier then edited and improved upon. Those magic words worked like a charm, and this second request was quickly approved by the landlord.

15. 42 U.S.C. § 3604(f)(3)(B) (2012) (defining discrimination on the basis of disability to include "a refusal to make reasonable accommodations in rules, policies, practices, or services, when such accommodations may be necessary to afford such person equal opportunity to use and enjoy a dwelling").

Not two weeks later, the social worker contacted Orier again with an update. "Orier," she said, "as I sit here on the phone with you, I am literally tearing up the suicide prevention plan. Mr. Lee has done a 180." Immediately upon receiving the approval from his landlord, Mr. Lee had gone to pick out his dog from a local animal shelter. The two of them had bonded right away, and Mr. Lee was taking the dog for several walks per day, interacting with his neighbors, making new human and canine friends at the dog park, and overall doing better than he'd done for years.

Again: preventive law.

Thus far I have focused on my own experiences within medical–legal partnership, but these are lessons that can be applied to all kinds of progressive legal work done with the goal of effecting social change. Here are some of my suggestions for students and lawyers alike:

1. Tell stories. Tell stories about your clients and create opportunities for your clients to tell their own stories. Very few people understand what exactly it is that public interest lawyers do all day, and stories are a powerful tool in talking about what we do, how we do it, and most importantly, why we do it.

2. Engage in cross-disciplinary collaboration. Every public interest attorney—regardless of field—should be interacting regularly with individuals and organizations from outside the law. Do not simply wait for clients to self-identify as having a legal problem and walk in your door. Talk to other people about what the most important issues facing our communities are. The list of people with whom you can collaborate is long: community organizers, environmental scientists, teachers, politicians, journalists, and so on.

3. Consider practicing public interest law outside New York, Washington, D.C., Chicago, Los Angeles, and San Francisco. The work that public interest attorneys do outside those five cities is just as important as the work done within them. There is great work being done all over the country. I found it enormously satisfying to serve in my home state of Ohio.

4. Lastly, remember what it's all for. Achieving real social change of any kind, on any scale is hard. It can be frustrating. It can be boring. But it is so important to the lives of the people and communities we serve, and somewhere in the back of your mind you have to hold fast to that idea of the good and fully honor the moments that celebrate our successes. You have to.

I'll leave you with one last story that maybe makes this point more eloquently than I am able to. It's a story of immigration, a teenager, and Supreme Court Justice Sonia Sotomayor.

In 2010, Justice Sotomayor came to Cleveland for several days. To cap off her visit, she was the honored guest at Legal Aid's annual community gala, an event I attended. A young woman named Brenda, a former client of my MLP colleague Megan Sprecher, delivered an introductory address immediately preceding Justice Sotomayor's remarks.

This 17-year-old high school senior absolutely brought down the house. In front of not only the first Latina Supreme Court Justice, but also more than a thousand lawyers and other community members, Brenda described coming to Cleveland with her parents and sisters as an undocumented immigrant from South America. With precocious poise and strength, she described the violence that she, her mother, and her sisters endured for years at the hands of her father. She talked of her mother's courage in finally leaving her father. She explained how Legal Aid helped her mother get a protective order and divorce from her father and helped them all gain documented immigration status through a U-visa, a pathway to citizenship for victims of crime.[16] And she talked about how the legal care that transformed her family inspired her to set her sights on attending law school and becoming an attorney herself. She admitted feeling scared to speak in front of all of us, but did so because her mother had convinced her "to show that people can overcome abuse."[17]

As the audience gave Brenda a standing ovation, Justice Sotomayor came up to her, held both her hands, and spoke quietly to her. There was not a dry eye in the auditorium.

Justice Sotomayor then came to the podium, and the first thing she said was in Spanish, to Brenda's mother: "Señora, I know you've been through a terrible ordeal, but you've been brave and done your daughters proud. They will grow up strong like you."[18]

She then turned to Brenda, the seventeen-year-old who had just spoken before us: "Brenda, every once in a while everyone tires of the work they are doing. Every professional in this room knows what I'm talking about….Every time that happens to me in the future, I'll think of you."[19]

A moment like that, and the future it allows us to imagine, is what it's all for.

16. *See* 8 C.F.R. § 214.14 (2014) (regulations defining U-visa eligibility).

17. Robert L. Smith, *Justice Sotomayor Charms and Inspires a Crowd in Cleveland*, CLEVELAND PLAIN DEALER, (Sept. 10, 2010, 11:30 PM), http://blog.cleveland.com/metro/2010/09/justice_sotomayor_thanks_legal.html.

18. Justice Sonia Sotomayor, Address at the Legal Aid Society Annual Community Gala (Sept. 9, 2010) (translation provided during interview with Megan Sprecher, Apr. 15, 2013).

19. Smith, *supra* note 17.