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Letter from the Editor-in-Chief

This third and final issue of Volume 65 of the *Howard Law Journal* is dedicated to the Eighteenth Annual Wiley A. Branton Symposium (the "Symposium"). The Symposium honors the legacy of former Howard University School of Law Dean and civil rights pioneer, Wiley A. Branton. During the Symposium, students, scholars, academicians, and advocates engage in discourse that represents and honors Wiley A. Branton's fight for social justice. Our goal each year is to provide thoughtful and productive dialogue and scholarship on legal issues that push us toward a more just society. The articles in this issue accomplish that goal.

The *Howard Law Journal* hosted the Eighteenth Annual Wiley A. Branton Symposium on October 7, 2021. The theme was *Health Equity: Developments & Challenges of the COVID-19 Pandemic*. Amid a global pandemic, the health crisis in our country has revealed the inequities in our healthcare system and highlighted the need for more robust public health laws. The speakers addressed the state of health equity and the implications of the current health crisis by addressing the impact of COVID-19 on communities of color, maternal and child health, solutions to health disparities, and access to resources and healthy environments. Included here in our Eighteenth Annual Branton Symposium issue are articles about health equity written by our distinguished Symposium panelists and scholars.

Issue 3 of Volume 65 begins with Brian Smith, Montrece Ransom, Whitney Magendie, and Tamia Perez's article *Public Health Law in the 21st Century: Evolution, Emerging Issues, and Equity*. Their article discusses the government's role in shaping the public health infrastructure and challenges its mediocrity. They also analyze areas of public health law, particularly in the aftermath of the COVID-19 pandemic. Their article explains how the law can serve as a tool in the quest for health equity and provide solutions through health law compliance to create more equitable outcomes.

Next, Joshua Porterfield, Beth Blauer, and Lainie Rutkow discuss the importance of demographic data in their article *Demographic Data and the Covid-19 Pandemic: A Regulatory Conundrum*. The article explores the role of demographic data in an effective response to public health crises, particularly in response to COVID-19. The authors assess demographic disparities in data and propose a solution of allocating funds to rebuild data infrastructure in the United States. Through a more detailed demographic data reporting system, Rutkow et al. argue that public health issues can be better solved by improving demographic information.

Third, in her article, *Policy Proceeds Law: A Global Analysis of Mental Health as a Human Right*, public health analyst Mara Howard-Wil-

liams discusses legal epidemiology to evaluate global mental health law. By examining the mental health culture on a global scale, Howard-Williams explores the World Health Organization's mental health action plan. Additionally, Howard-Williams compares how changes in law and policy impact mental health data. Finally, the author provides action-based recommendations to address mental health globally.

Our final symposium article, authored by Jill Morrison and Anna Reed, is *Taking Food from the Mouths of Babes: WICs Punitive Treatment of Lower-Income Mothers Who Won't or Can't Breastfeed*. In their article, Morrison and Reed argue that the current WIC regulation should be eliminated because it currently provides more financial benefits to women who breastfeed than women who do not. The authors further discuss breastfeeding and the impact it has on reproductive justice. The article undermines WIC's notion that breastfeeding is healthier for infants and instead advocates for WIC not to penalize women who do not, or cannot, breastfeed. They argue that WIC should individually assess each family's financial needs.

The final two pieces of Volume 65's Issue 3 are notes authored by *Howard Law Journal* members. The first Note, written by Senior Articles Editor Zariah Altman, *Speech on Trial? An Exploration into the Effects of Lingual Discrimination on African American Vernacular English Speakers* discusses discrimination that African American Vernacular English ("AAVE") speakers experience in our legal system. She analyzes the biases AAVE speakers experience in a criminal context, specifically as witnesses or suspects, and how their vernacular can then harm them. Altman provides solutions to protect AAVE speakers from discrimination in the legal system.

Lastly, Senior Staff Editor Kufere Laing, in his Note, *Interpreting the People's Constitution: Pauli Murray's Intersectionality as a Method of Constitutional Interpretation*, explores Pauli Murray's legal intersectionality framework as a method of constitutional interpretation. Laing delves into the *Marbury v. Madison* and *Dred Scott v. Sanford* cases to provide context for interpretive methods and judicial review. The author emphasizes the factors that judges should consider when interpreting the Constitution, and argues that Pauli Murray's interpretive approach to the Equal Protection Clause should be widely regarded to ensure social justice.

On behalf of the *Howard Law Journal*, I thank you for your continued support and readership. It has been an honor to serve as Editor-in-Chief of Volume 65. I take pride in the work that we have accomplished as a *Journal* this year and the rewarding and inspiring scholarship that we have published. The articles and notes from the authors that grace the pages of our *Journal* exemplify brilliance and dedication toward expanding the conversations about social justice, civil rights, and public policy. I am forever grateful for the commitment and ardor of the *Howard Law Journal* Staff

and extend my gratitude and appreciation to Volume 65's Executive Board: Bethany Thomas, Reinaldo Franqui Machin, Anna Williams, and Oluwaseun Awotunde. I would also like to thank our Faculty Advisors, Business Manager, and staff editors for their tireless work to ensure our *Journal* was a success. I have great confidence that the *Howard Law Journal* will continue to produce scholarship that upholds our commitment to excellence, tackles issues that challenge the status quo, and leads us to better understand and solve the legal problems that impact our communities and the world. I am pleased to present to you Issue 3 of Volume 65 of the *Howard Law Journal.*

Adrienne R. Parms
Editor-in-Chief
Volume 65

Wiley A. Branton/ Howard Law Journal Symposium:

Each year, Howard University School of Law and the Howard Law Journal pay tribute to the life and legacy of our former dean, Wiley A. Branton. What began as a scholarship award ceremony for the first-year student who completed the year with the highest grade point average has grown into a day-long program that focuses on an area of legal significance inspired by Branton's career as a prominent civil rights activist and exceptional litigator. The Symposium is then memorialized in the Journal's spring issue following the Symposium. The expansive nature of Branton's work has allowed the Journal to span a wide range of topics throughout the years, and the Journal is honored to present this issue, Health Equity: Developments & Challenges of the COVID-19 Pandemic, in recognition of the great Wiley A. Branton. Past Symposium issues include:

An Environment of Justice: Developments & Challenges in Environmental Law

Unfinished Work of the Civil Rights Act of 1964: Shaping an Agenda for the Next 40 Years

The Value of the Vote: The 1965 Voting Rights Act and Beyond

What Is Black?: Perspectives on Coalition Building in the Modern Civil Rights Movement

Katrina and the Rule of Law in the Time of Crisis

Thurgood Marshall: His Life, His Work, His Legacy

From Reconstruction to the White House: The Past and Future of Black Lawyers in America

Collateral Consequences: Who Really Pays the Price for Criminal Justice?

Health Care Reform and Vulnerable Communities: Can We Afford It? Can We Afford to Live Without It?

Protest & Polarization: Law and Debate in America 2012

Civil Rights at a Critical Juncture: Confronting Old Conflicts and New Challenges

Public Health Law in the 21st Century: Evolution, Emerging Issues, and Equity[1]

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1. The findings and conclusions in this article are those of the authors alone and do not represent the views of the Centers for Disease Control and Prevention, the National Network of Public Health Institutes, the University of Nevada-Las Vegas, William S. Boyd School of Law, or any other affiliate of the authors, past or present.

I. INTRODUCTION

Arguably, there has never been a more important time for public health law than in the wake of the COVID-19 pandemic.[2] The pandemic bluntly exposed fault lines across the healthcare industry and the nation's public health system, opening policy windows to address health equity, disease reporting, and other pressing issues.[3] The ongoing nature of the pandemic has placed long-established public health legal frameworks—such as executive emergency powers and vaccination laws—under intense scrutiny.[4] Meanwhile, public health departments and officials using their legal powers have faced political undermining and power grabs.[5]

2. *See* Vivek Kaul, Vijay H. Shah, & Hashem El-Serag, *Leadership During Crisis: Lessons and Applications from the COVID-19 Pandemic*, 159 GASTROENTEROLOGY 809, 809 (2020), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7233251/.

3. *See, e.g.*, Valerie Wilson, *Inequities Exposed: How COVID-19 Widened Racial Inequities in Education, Health, and the Workforce*, ECON. POLICY INST. (June 22, 2020), https://www.epi.org/publication/covid-19-inequities-wilson-testimony/.

4. *See, e.g.*, Dareh Gregorian, *Judge Issues Nationwide Injunction Against Biden's Vaccination Mandate for Federal Contractors*, NBC NEWS (Dec. 7, 2021, 3:05 PM), https://www.nbcnews.com/politics/joe-biden/judge-issues-nationwide-injunction-against-biden-s-vaccine-mandate-federal-n1285551.

5. *See, e.g.*, Rebecca Shabad, *Trump White House Made 'Deliberate Efforts' to Undermine Covid Response, Report Says*, NBC NEWS (Dec. 17, 2021, 12:20 PM), https://www.nbcnews.com/politics/congress/trump-white-house-made-deliberate-efforts-undermine-covid-response-report-n1286211.

Throughout the pandemic, law has played a pivotal role in shaping the public health response.[6] Attorneys across public and private sectors have worked diligently to respond to the crisis; their work has helped to keep hospitals, businesses, schools, courts, and governments afloat.[7] Judges have rendered key decisions shaping how public health laws are interpreted and applied.[8] Paralegals and administrative support professionals have kept law practices running despite unprecedented barriers to in-person contact.[9] Similarly, public health practitioners have drawn upon their understanding of the power and limitations of law to determine what policies they can and should institute to reduce the threat of mortality and morbidity, and to anticipate barriers to successful policy creation and implementation.[10] But COVID-19 is not over nor is it the last pandemic that we will face.[11] Considering the widespread attention towards public health law, and the key role of attorneys in safeguarding the public's health, it is vital to examine the fundamentals of public health laws and their broad applicability.

This paper touches on four overarching themes. First, we provide an overview of how government structures shape public health infrastructure and legal preparedness. Much of this theme centers on the authority governments have to implement public health measures, as well as how governments leverage legal authorities to prepare for public health issues.

Second, we identify fundamental and developing areas of public health law, including public health emergency powers, public health surveillance, legal epidemiology, and racism as a public health issue. These areas of the law are currently being revisited in the wake of COVID-19, and frameworks are largely still in a nascent stage; this

6. *See COVID-19 Laws and Legal Resources*, JUSTIA, https://www.justia.com/covid-19/ (last visited Feb. 15, 2022).

7. *See* Lyle Moran, *The High Demand for Lawyers Amid the Coronavirus Pandemic*, ABA J. (Mar. 17, 2020), https://www.abajournal.com/web/article/lawyers-and-law-firms-say-they-are-inundated-with-coronavirus-related-queries.

8. *See, e.g.*, Jacob Gershman, *Judges Weigh More Biden Vaccine-Mandate Cases After Supreme Court Rulings*, WALL ST. J. (Feb. 6, 2022, 5:30 AM), https://www.wsj.com/articles/judges-weigh-more-biden-vaccine-mandate-cases-after-supreme-court-rulings-11644143401.

9. *See Guidance for Paralegal Programs Regarding the COVID-19 Pandemic*, ABA, https://www.americanbar.org/groups/paralegals/guidance/ (last visited Feb. 15, 2022).

10. *See, e.g.*, Thomas V. Inglesby, *Public Health Measures and the Reproduction Number of SARS-CoV-2*, JAMA INSIGHTS (May 1, 2020), https://jamanetwork.com/journals/jama/fullarticle/2765665.

11. *See* Victoria Gill, *Coronavirus: This Is Not the Last Pandemic*, BBC NEWS (June 6, 2020), https://www.bbc.com/news/science-environment-52775386.

transitionary point in time presents an important opportunity to create, monitor, and adapt to modern public health laws and policies.

Third, we describe how law and legal practice can advance health outcomes and equity. Specifically, we outline how compliance with public health laws can lead to equitable outcomes. For example, we describe public health laws focused on improving healthcare disparities and showcase areas where attorneys across diverse practice areas can incorporate public health principles into advancing the needs of their clients. We also uplift the role and responsibility of public health practitioners in understanding and informing public health law as a critical component of an effective health equity strategy.

Finally, we provide examples of changes in state and local public health authority since COVID-19. As governments continue efforts to either bolster or limit public health powers, variations in public health laws across jurisdictions could foreshadow patchwork responses for future public health crises.

II. GOVERNMENT STRUCTURE, PUBLIC HEALTH INFRASTRUCTURE, AND LEGAL PREPAREDNESS

A. Basic Government Structure

Governments are largely responsible for carrying out public health based on authority derived from constitutions.[12] The U.S. Constitution sets out the "few and defined"[13] enumerated powers of the federal government, expressly stating the powers of the Executive, Legislative, and Judicial Branches (*e.g.*, the power to regulate commerce).[14] Additionally, the U.S. Constitution has implied powers, as broadly defined through judicial decisions.[15] Finally, there are concurrent powers, in which both the federal and state governments have authority to act (*e.g.*, the power to collect taxes).[16]

12. INST. OF MED., THE FUTURE OF THE PUBLIC'S HEALTH IN THE 21ST CENTURY 101 (2002), https://www.ncbi.nlm.nih.gov/books/NBK221231/ (hereinafter "INST. OF MED.").

13. THE FEDERALIST NO. 45 (James Madison).

14. I.N.S. v. Chadha, 462 U.S. 919, 951 (1983) ("The Constitution sought to divide the delegated powers of the new federal government into three defined categories, legislative, executive and judicial, to assure, as nearly as possible, that each Branch of government would confine itself to its assigned responsibility.").

15. *See* M'Culloch v. Maryland, 17 U.S. 316, 406 (1819).

16. *See* Gibbons v. Ogden, 22 U.S. 1, 42 (1824).

The powers not listed in the U.S. Constitution are reserved for the states under the Tenth Amendment.[17] As the U.S. Constitution is specific, it does not provide for a general "police power"[18] to uphold the public good.[19] Thus, under the Tenth Amendment, general police powers are reserved for the states.[20]

This structure embodies the core of federalism, in which both the federal and state governments govern within their own spheres of influence.[21] Importantly, the U.S. Constitution specifies how the federal government may operate independent of the states—this gives states exclusive areas of policy to govern.[22] When federal and state authority conflict, the Supremacy Clause requires that states yield to the federal government.[23] When there is no federal authority for an area of policy, that area is left to the states to govern.[24]

States have their own constitutions outlining their executive, legislative, and judicial powers.[25] Localities within states derive their authority either from the state constitution or through statute.[26] Each state has a different arrangement with how much governing power the state and local jurisdictions have.[27]

B. Basic Public Health Infrastructure

Broadly, "public health infrastructure" refers to the systems required to enable strong public health services such as vaccinations, chronic disease prevention initiatives, and emergency response efforts.[28] Central to a strong public health infrastructure is a "capable and qualified workforce, up-to-date data and information systems,

17. U.S. CONST. AMEND X ("The powers not delegated to the United States by the Constitution, nor prohibited by it to the states, are reserved to the states respectively, or to the people.").

18. *See* Berman v. Parker, 348 U.S. 26, 32 (1954).

19. *See* United States v. Morrison, 529 U.S. 598, 618–619 (2000).

20. *See* Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519, 536 (2012).

21. See Doug Farquhar, Jessika M. Douglas, & Brian A. Smith, *State Implementation of Federal Environmental Laws*, 31 HEALTH MATRIX: J. LAW-MEDICINE 263, 264 (2021), https://scholarlycommons.law.case.edu/healthmatrix/vol31/iss1/11.

22. *See* Gibbons v. Ogden, 22 U.S. 1, 31–32 (1824).

23. *See* Hines v. Davidowitz, 312 U.S. 52, 62–63 (1941).

24. *See* Arizona v. United States, 567 U.S. 387, 400 (2012).

25. *See generally* ROBERT L. MADDEX, STATE CONSTITUTIONS OF THE UNITED STATES (2nd ed., 2006).

26. Hunter v. City of Pittsburgh, 207 U.S. 161, 178 (1907) ("Municipal corporations are political subdivisions of the state, created as convenient agencies for exercising such of the governmental powers of the state as may be entrusted to them.").

27. *See State and Local Government*, WHITE HOUSE, https://www.whitehouse.gov/about-the-white-house/our-government/state-local-government/ (last visited Feb. 25, 2022).

28. INST. OF MED., *supra* note 12, at 96.

and agencies that can assess and respond to public health needs."[29] There are many stakeholders contributing to public health infrastructure, including non-profit organizations, healthcare insurers, healthcare systems, and technology companies, but it is government agencies—especially health and public health departments—that provide the backbone of the nation's public health system.[30]

As "public health" is not found in the U.S. Constitution, state and local governments retain the primary responsibility for public health under the Tenth Amendment.[31] In fulfilling this responsibility, states and localities commonly use public health departments to perform activities such as monitoring the burden of injury and disease through public health surveillance systems, using testing and reporting methods to identify individuals and groups with certain health conditions, and providing preventative health services and education.[32]

State and local regulations also bolster public health infrastructure.[33] For example, food safety regulations (*e.g.*, health department inspections and restaurant licenses) require restaurants and other businesses in the food industry to be safe and sanitary.[34] Smoke-free laws at the state and local level protect constituents from secondhand smoke exposure, yielding a measurable decrease in hospitalizations for some of the most vulnerable populations.[35] Another example includes oversight of healthcare providers who might overprescribe or inappropriately prescribe certain medications such as antibiotics or opioids.[36]

Federal statutes have been enacted creating the federal public health infrastructure.[37] The vast majority of federal public health in-

29. U.S. DEP'T OF HEALTH & HUMAN SERVS., *Public Health Infrastructure*, https://health.gov/healthypeople/objectives-and-data/browse-objectives/public-health-infrastructure (last visited Oct. 11, 2021).

30. Eileen Salinsky, *Governmental Public Health: An Overview of State and Local Public Health Agencies*, NAT'L HEALTH POL'Y F. 22 (Aug. 18, 2010), https://www.nhpf.org/library/background-papers/BP77_GovPublicHealth_08-18-2010.pdf.

31. INST. OF MED., *supra* note 12, at 102.

32. *See* Salinsky, *supra* note 30, at 16.

33. INST. OF MED., *supra* note 12, at 102.

34. *Id.* at 72.

35. Mark W. Vander Weg, Gary E. Rosenthal, & Mary Vaughan Sarrazin, *Smoking Bans Linked to Lower Hospitalizations for Heart Attacks and Lung Disease Among Medicare Beneficiaries*, 31 HEALTH AFFAIRS 2699, 2704 (2012), https://pubmed.ncbi.nlm.nih.gov/23213154/; Crystal E. Tan & Stanton A. Glantz, *Association Between Smoke-Free Legislation and Hospitalizations for Cardiac, Cerebrovascular, and Respiratory Diseases*, 126 CIRCULATION 2177, 2181 (2012), https://www.ahajournals.org/doi/10.1161/circulationaha.112.121301.

36. INST. OF MED., *supra* note 12, at 102

37. *See id*. at 102–03.

frastructure stems from federal agencies, primarily through the Public Health Service within the Department of Health and Human Services ("HHS").[38] There are eight Public Health Service agencies: the Agency for Healthcare Research and Quality ("AHRQ"), the Centers for Disease Control and Prevention ("CDC"), the Agency for Toxic Substances and Disease Registry ("ATSDR"), the Food and Drug Administration ("FDA"), the Health Resources and Services Administration ("HRSA"), the Indian Health Service ("IHS"), the National Institutes of Health ("NIH"), and the Substance Abuse and Mental Health Services Administration ("SAMHSA").[39] These agencies are devoted to public health services but have varying functions.[40] Specifically, NIH and AHRQ are research-based agencies; NIH serves as the country's lead biomedical research center,[41] while AHRQ is the country's lead research center on health care delivery and quality.[42] IHS, HRSA, and SAMHSA are agencies that directly provide healthcare services or bolster existing systems providing healthcare services.[43] Specifically, IHS provides healthcare services for American Indian/Alaska Native populations,[44] HRSA sponsors programs designed to improve healthcare access for the medically underserved (*e.g.*, rural populations, low-income populations, etc.),[45] and SAMHSA sponsors community-based mental health and substance abuse treatment programs.[46] CDC and ATSDR (which is overseen by the CDC Director) are agencies focused on developing and support-

38. C. Stephen Redhead, Agata Dabrowska, Erin Bagalmen, Elayne J. Heisler, Judith A. Johnson, Sarah A. Lister & Amanda K. Saratu, Cong. Rsch. Serv., Public Health Service Agencies: Overview and Funding (FY2016-FY2018) 1 (2017), https://fas.org/sgp/crs/misc/R44916.pdf.

39. *Id*.

40. *See id.*

41. *Id.* For more on how NIH allocates its funding through grants, see W. Nicholson Price II, *Grants*, 34 Berkeley Tech. L. J. 1, 19–20 (2019) ("[T]he largest funder of grant-based research by far, focusing entirely on biomedical science, is the NIH, 'the center of a vast research system unmatched in size and scope throughout the world.' The NIH comprises twenty-seven different Institutes and Centers (collectively, 'Institutes'), each focused on a 'specific disease area, organ system, or stage of life'; examples include the National Cancer Institute, the National Human Genome Research Institute, and the National Institute on Aging. Of these, twenty-four make grant awards. The NIH expends about $37.3 billion in biomedical research per year; 10% of that is spent on its own intramural research programs, and around 80% on extramural grants. '[I]n the market for biomedical research, NIH is the 800-pound gorilla.'").

42. Redhead et al., *supra* note 38, at 1.

43. *Id.*

44. *Id.*

45. *Id.*

46. *Id.*

ing population-based public health systems to promote quality of life and prevent leading causes of injury.[47]

The federal public health infrastructure plays a key role during public health emergencies.[48] In such emergencies, the federal government can mobilize resources through legislation.[49] Executively, national emergency declarations by the President, public health emergency declarations by the HHS Secretary, and other policy measures such as Food and Drug Administration emergency use authorizations or HHS Section 1135 waivers can be used to respond to emergencies.[50] In addition, guidelines from agencies such as the CDC or the Occupational Safety and Health Administration can help guide businesses, individuals, and healthcare providers. Judicially, federal courts impact public health infrastructure through their interpretations of public health statutes. For example, the Supreme Court has ruled on vaccine requirements,[51] the right to contraception and abortion,[52] and the constitutionality of the Patient Protection and Affordable Care Act,[53] all of which significantly impact the public health system.

C. Legal Preparedness

When public health emergencies occur—such as during bioterrorism events (*e.g.*, the 9/11 anthrax attacks), natural disasters (*e.g.*, Hurricane Katrina), and infectious disease outbreaks (*e.g.*, COVID-19)—it is vital for public health officials to have clarity on their roles and responsibilities.[54] Without clear laws outlining how the public health system should operate in an emergency, the public health response could become fragmented and inefficient.[55] Such an outcome has dev-

47. *Id.*

48. INST. OF MED., *supra* note 12, at 99–100.

49. *See Factbox: What's in the $2 Trillion U.S. Senate Coronavirus Rescue Package*, REUTERS (Mar. 24, 2020, 4:20 PM), https://www.reuters.com/article/us-health-coronavirus-usa-bill-factbox/factbox-whats-in-the-2-trillion-u-s-senate-coronavirus-rescue-package-idUSKBN21B37G.

50. *Public Health Emergency Declaration*, U.S. DEP'T OF HEALTH & HUMAN SERVS. (Nov. 26, 2019), https://www.phe.gov/Preparedness/legal/Pages/phedeclaration.aspx.

51. *E.g.*, Jacobson v. Massachusetts, 197 U.S. 11, 39 (1905).

52. *E.g.*, Roe v. Wade, 410 U.S. 113, 164 (1973).

53. *E.g.*, Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519, 588 (2012).

54. *See Public Health Emergency Law: Legal Preparedness Series*, ASSOC. OF STATE & TERRITORIAL HEALTH OFF., https://astho.org/Legal-Preparedness-Series/ (last visited Oct. 11, 2021).

55. *See, e.g.*, *Public Health Emergency Preparedness and Response Capabilities: National Standards for State, Local, Tribal, and Territorial Public Health*, U.S. CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/cpr/readiness/capabilities.htm (last visited Oct. 11, 2021).

astating effects on the population's health and wellbeing, as well as local and national economic security.[56]

Public health legal preparedness generally refers to the implementation, use, and understanding of laws that bolster the public health system and its essential services.[57] An example of legal preparedness is where public health officials understand when and how to issue a public health emergency order, including how to mobilize and deploy certain staff to respond to the emergency.[58]

1. Crisis Standards of Care

Preparing for the worst public health crises also involves creating plans for when everything goes wrong. Throughout the COVID-19 pandemic, some healthcare systems had to maneuver what is known as "crisis standards of care."[59] These crisis standards occur when there is not enough space, staff, or supplies to provide the regular standards of care. For example, hospitals and other clinical settings may use crisis standards of care when encountering substantial changes in their usual healthcare operations and the level of care it is possible to deliver, such as when there is a pervasive (*e.g.*, pandemic, war, etc.) or catastrophic (*e.g.*, earthquake, hurricane, etc.) disaster. For many healthcare settings, COVID-19 served as the first occurrence of implementing crisis standards of care,[60] and for good reason—when these standards are in place, there is a utilitarian shift in focus from saving individual patients to that of saving the most lives.[61] This means that some patients will be prioritized over others based on

56. *Fiscal Year 2022: Justification of Estimates for Appropriations Committees*, U.S. DEP'T OF HEALTH & HUMAN SERVS. 12, https://www.cdc.gov/budget/documents/fy2022/FY-2022-CDC-congressional-justification.pdf (last visited Oct. 11, 2021).

57. *See* Anthony D. Moulton, Richard N. Gottfried, Richard A. Goodman, Anne M. Murphy & Raymond D. Rawson, *What is Public Health Legal Preparedness?*, 31 J. L. MED. & ETHICS 672, 674 (2003).

58. *Administrative Preparedness Legal Guidebook*, NAT'L ASSOC. OF COUNTY & CITY HEALTH OFFICIALS, https://www.naccho.org/programs/public-health-preparedness/systems-preparedness/administrative-preparedness-legal-guidebook (last visited Oct. 11, 2021).

59. *See, e.g.*, Rebecca Boone, *COVID-19 Surge Forces Health Care Rationing in Parts of West*, ASSOC. PRESS (Sept. 16, 2021), https://apnews.com/article/health-public-health-coronavirus-pandemic-idaho-a0729894b42af1c3dadeccaffeabea0c.

60. *See, e.g.*, Nate Rattner, Lauren Feiner, & Spencer Kimball, *U.S. Covid Fatalities Reach Highest Level in a Year as Omicron Cases Subside*, CNBC (Feb. 1, 2022, 11:03 AM), https://www.cnbc.com/2022/02/01/us-covid-fatalities-reach-highest-level-in-a-year-as-omicron-cases-subside.html.

61. NAT'L ACAD. OF SCI., ENG'G, AND MED., RAPID EXPERT CONSULTATION ON CRISIS STANDARDS OF CARE FOR THE COVID-19 PANDEMIC 1 (2020), https://www.nap.edu/read/25765/chapter/1.

many factors, such as underlying health status or current health scores based on intensive care measures.[62]

In short, public health legal preparedness greatly assists the numerous public health stakeholders in responding to public health emergencies. Knowledge of laws and regulations can help answer key questions involving whether certain actions can occur, must occur, or should occur in response to an emergency.[63] Attorneys working for clients involved in public health emergency response should be familiar with the variety of legal preparedness toolkits and resources available,[64] including legal protections of state and local health officials making public health emergency decisions.[65]

III. FUNDAMENTAL AND DEVELOPING AREAS OF PUBLIC HEALTH LAW

A. Public Health Basics

"Public health" generally refers to the "health of the community at large," "the healthful or sanitary condition of the general body of people or the community en masse," or "the methods of maintaining the health of the community, as by preventive medicine and organized care for the sick."[66] These broad definitions illustrate the sizable responsibility of public health departments and other agencies tasked with safeguarding and promoting public health. But government agencies are not the sole protectors of public health. As an Institute of Medicine report describes, public health encompasses "what we as a society do collectively to assure the conditions in which people can be healthy."[67]

Those involved in public health include first responders, restaurant inspectors, health educators, scientists and researchers, nutrition-

62. *E.g.*, *Allocation of Scarce Medical Resources in a Pandemic: Recommended Framework for Maryland*, MARYLAND HEALTHCARE ETHICS COMM. NETWORK 1–2, https://www.law.umaryland.edu/media/SOL/pdfs/Programs/Health-Law/MHECN/Maryland%20SRA%20Framework%20110221.pdf (last visited Feb. 15, 2022).

63. *Legal Aspects of Public Health Emergency Preparedness*, NORTHWEST CTR. FOR PUBLIC HEALTH PRAC. 2, https://www.nwcphp.org/docs/law-preparedness/emergency-preparedness-print.pdf (last visited Oct. 11, 2021).

64. *Emergency Preparedness*, U.S. CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/phlp/publications/topic/emergency.html (last visited Oct. 11, 2021).

65. *Legal Protections for Public Health Officials*, NETWORK FOR PUBLIC HEALTH L. (Nov. 2020), https://www.networkforphl.org/wp-content/uploads/2020/11/50-State-Survey-Legal-Protections-for-Public-Health-Officials.pdf.

66. *Health*, BLACK'S LAW DICTIONARY (11th ed. 2019).

67. INST. OF MED., *supra* note 12, at 2.

ists, community planners, social workers, epidemiologists, public health physicians and nurses, occupational health and safety professionals, policymakers, sanitarians, and lawyers.[68] These stakeholders play key roles in carrying out the ten essential public health services, including using legal and regulatory actions (see Figure 1)[69].

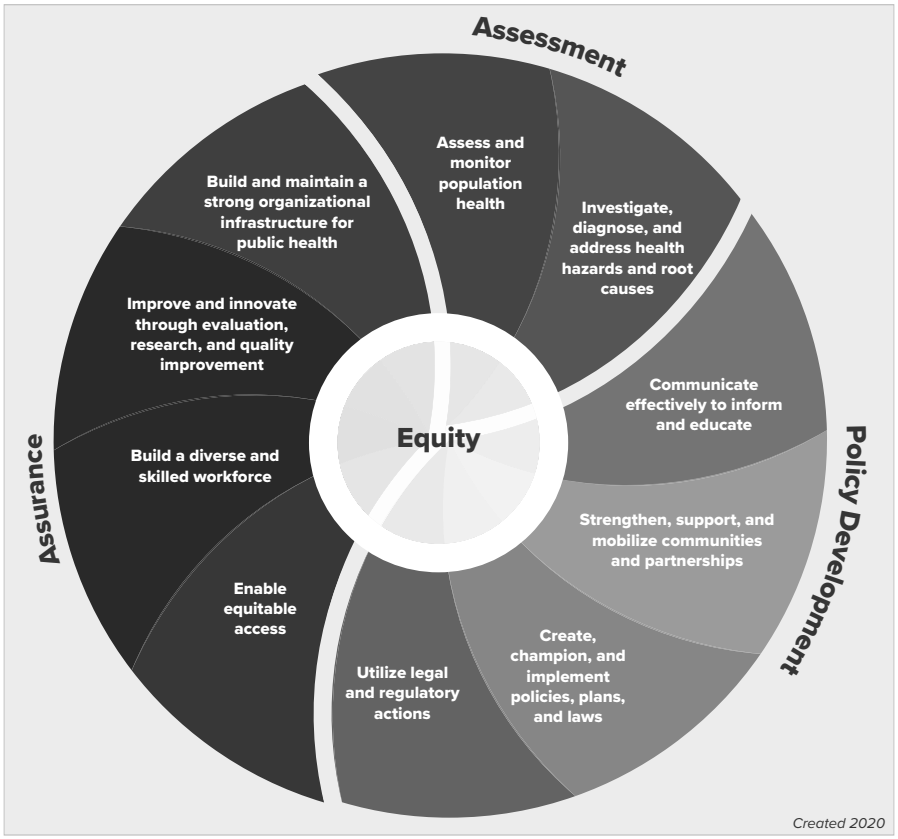

Figure 1: The 10 Essential Public Health Services. This framework includes the following services: (1) ASSESS AND MONITOR population health. (2) INVESTIGATE, DIAGNOSE AND ADDRESS health hazards and root causes. (3) COMMUNICATE EFFECTIVELY to in-

68. *See What is Public Health?*, AM. PUB. HEALTH ASS'N, https://www.apha.org/what-is-public-health (last visited Oct. 7, 2021); *See generally* Peter D. Jacobsen, Jeffrey Wasserman, Anda Botoseneanu, Amy Silverstein & Helen W. Wu, *The Role of Law in Public Health Preparedness: Opportunities and Challenges*, 37 J. HEALTH POL., POL'Y & L. 297, 298 (2012), https://doi.org/10.1215/03616878-1538629.

69. For more on the essential public health services, *see Public Health Essentials in Action Online*, W. REGION PUB. HEALTH TRAINING CTR., https://www.phlearningnavigator.org/training/public-health-essentials-action-online (last visited Feb. 15, 2022) ("This multimedia training provides a dynamic look at some of the most fundamental aspects of public health from the unique points of view of members of the workforce and community members.").

> form and educate. (4) STRENGTHEN, SUPPORT AND MOBILIZE communities and partnerships. (5) CREATE, CHAMPION AND IMPLEMENT policies, plans and laws. (6) UTILIZE LEGAL AND REGULATORY ACTIONS. (7) ENABLE EQUITABLE ACCESS. (8) BUILD A DIVERSE AND SKILLED workforce. (9) IMPROVE AND INNOVATE through evaluation, research and quality improvement. (10) BUILD AND MAINTAIN a strong organizational infrastructure for public health.[70]

As public health has evolved and the field's understanding of health disparities has advanced, social determinants of health ("SDOH") have emerged as a priority intervention point for systemic change to improve people's health and wellbeing at the population level.[71] SDOH are defined as "the conditions in the environments where people are born, live, learn, work, play, workshop, and age that affect a wide range of health, functioning, and quality of life outcomes and risks."[72] (See Figure 2).

70. *10 Essential Public Health Services,* AM. PUB. HEALTH ASS'N, https://www.apha.org/What-is-Public-Health/10-Essential-Public-Health-Services (last visited Feb. 15, 2022).

71. For more health disparities, see *Measuring Health Disparities*, REGION V PUB. HEALTH TRAINING CTR., https://www.phlearningnavigator.org/training/measuring-health-disparities (last visited Feb. 15, 2022) ("This interactive course focuses on how to understand, define and measure health disparity. This course examines the language of health disparity to come to some common understanding of what [health disparity] means, explains key measures of health disparity and shows how to calculate them. The course is designed to be accessible to a broad audience of practitioners across all sectors of the public health and related workforce who are concerned about the issue of health disparity.").

72. *Social Determinants of Health - Healthy People 2030*, U.S. DEP'T HEALTH & HUM. SERVS., https://health.gov/healthypeople/objectives-and-data/social-determinants-health (last visited Feb. 15, 2022).

Figure 2: The Social Determinants of Health. Five domains (education access and quality, health care access and quality, neighborhood and built environment, social and community context, and economic stability) make up the overarching framework of SDOH, as used in Healthy People 2030.[73]

Law plays a key role in implementing and sustaining systemic change across the five SDOH domains, with examples ranging from establishing minimum wage (Economic Stability) to enshrining the right to equal educational opportunity (Education Access and Quality) to preventing pollution that makes air and water unsafe (Neighborhood and Built Environment).[74] For public health practitioners, collaboration with sectors outside of public health, including transpor-

73. *Id.*
74. *Id.*

tation, housing, and law, is critical for making meaningful systems-level improvements to the conditions in which people live.[75]

B. Public Health Law Basics

Public health law is derived from the same sources of other areas of law: constitutions, treaties, statutes, regulations, and common law.[76] Federalism—the distribution of governing authority between national government and individual states—plays a paramount role in shaping public health law at the national, state, and local levels.[77] Legislatures enact public health statutes, executives and agencies enforce laws and promulgate regulations, and the judiciary interprets laws and regulations while identifying their limits.[78]

Most public health activities are carried out by states, by virtue of state police powers under the Tenth Amendment.[79] Federal statutes have created roles for the federal government in public health, such as the creation of the public health agencies described above.[80] Because of the multidimensional organization of the country's public health system and corresponding laws, healthcare attorneys must be able to distinguish which laws apply and when.

This overarching theme—preemption—is a constant issue to consider when evaluating public health laws and decisions.[81] Preemption largely refers to the Supremacy Clause of the U.S. Constitution and analogous clauses in state constitutions, in that laws made in higher levels of government will supersede laws made in lower levels of government.[82] There is "express preemption," which occurs when "a law contains a preemption clause or other explicit preemptive language,"

75. For more on interprofessional practice and collaboration, see *Interprofessional Practice for Population Health*, REGION V PUB. HEALTH TRAINING CTR., https://www.phlearningnavigator.org/training/interprofessional-practice-population-health (last visited Feb. 15, 2022) (As "[i]t is increasingly understood that collaboration across disciplines is required to advance population health and health equity," this training "defines the core competencies of interprofessional education and illustrates their importance within public health through practice-based examples.").

76. *See Public Health Law 101: Unit 1*, U.S. CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/phlp/docs/phl101/PHL101-Unit-1-16Jan09-Secure.pdf (last visited Feb. 15, 2022).

77. *Id.*

78. *Id.*

79. *See* INST. OF MED, *supra* note 12, at 103–04.

80. *See supra* Part II.B.

81. *See Preemption*, PUB. HEALTH L. CTR., https://www.publichealthlawcenter.org/topics/commercial-tobacco-control/preemption (last visited Feb. 15, 2022).

82. *Id.*

and "implied preemption," which is when "a court finds that a law is preemptive even in the absence of an express preemption clause."[83]

Preemption can serve as a barrier to improved public health outcomes. For example, preemption has long been used by some states as a way to reverse local tobacco control laws and prevent the enactment of such laws in the future.[84] During the COVID-19 pandemic, some state governments attempted to use preemption to reverse emergency response policies passed at the local level, such as Texas Governor Greg Abbott's executive order attempting to prevent local mask mandates.[85]

Alternatively, some preemption strategies may advance the goals of public health, such as federal packaging requirements regarding warning labels and other information on food, alcohol, and other products.[86] Attorneys and public health practitioners alike should be well versed in the potential of preemption as a powerful tool for those working to advance public health progress as well as a powerful barrier to stymie that progress.

C. Developing Areas of Public Health Law

Public health law has seen a significant increase in activity and changes over the past three decades.[87] As more government intervention into public health arises, new issues and methods involving these laws and regulations have come into the picture. Four areas are of particular contemporary importance: public health emergency powers; legal epidemiology; misinformation, disinformation, and trust in public health; and racism as a public health issue.

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83. Mark Pertschuk, *Preemption and the Public's Health*, PUB. HEALTH L. CTR. 4, https://www.publichealthlawcenter.org/sites/default/files/resources/phlc-pres-pertschukpreempt-6-10.pdf (last visited Feb. 15, 2022).

84. *See, e.g.*, *State Tobacco Activities Tracking and Evaluation (STATE) System Fact Sheet*, U.S. CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/statesystem/factsheets/preemption/Preemption.html (last visited Feb. 15, 2022).

85. Tx. Exec. Order No. GA 36 (May 18, 2021), https://gov.texas.gov/uploads/files/press/EO-GA-36_prohibition_on_mandating_face_coverings_response_to_COVID-19_disaster_IMAGE_05-18-2021.pdf.

86. *Impact of Preemptive Laws on Public Health*, AM. PUB. HEALTH ASS'N (Nov. 3, 2015), https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2016/01/11/11/08/impact-of-preemptive-laws-on-public-health.

87. *See* SCOTT BURRIS, MICAH L. BERMAN, MATTHEW PENN, & TARA RAMANATHAN HOLIDAY, THE NEW PUBLIC HEALTH LAW: A TRANSDISCIPLINARY APPROACH TO PRACTICE AND ADVOCACY 1, 172 (1st ed. 2018).

1. Public Health Emergency Powers

Executive emergency powers have been at the fore of governmental responses to public health emergencies.[88] Federally, these powers are scattered across several domains.[89] The President can issue executive orders to shape public health policy (such as orders to protect people with preexisting conditions and eliminate surprise medical bills)[90] and has the power to issue emergency declarations, generally under the authority granted through the Stafford Act[91] and National Emergencies Act.[92] The President's agenda related to a public health emergency can be imputed onto federal agencies including HHS and the Public Health Service. The President's appointed Secretary of HHS also has several tools available during public health emergencies.[93] For example, the Secretary can declare public health emergencies under the Public Health Service Act,[94] issue liability immunity under the Public Readiness and Emergency Preparedness Act,[95] and make waivers or modifications to Medicare, Medicaid, Children's Health Insurance Program ("CHIP") and Health Insurance Portability and Accountability Act ("HIPAA") requirements under Section 1135 of the Social Security Act.[96] During public health emergencies, HHS can tap into the Strategic National Stockpile, created in 1999 to "ensure the nation's readiness against potential agents of bi-

88. *See* Patsy Widakuswara, *How US Presidents Have Handled Public Health Crises*, VOA NEWS (Mar. 30, 2020, 8:20 A.M.), https://www.voanews.com/a/science-health_coronavirus-outbreak_how-us-presidents-have-handled-public-health-crises/6186561.html; Rachel Morgan & Joy Johnson Wilson, *Responsibilities in a Public Health Emergency*, NAT'L CONF. STATE LEGISLATURES (Oct. 29, 2014), https://www.ncsl.org/research/health/public-health-chart.aspx.

89. JENNIFER K. ELSEA, JAY B. SYKES, JOANNA R. LAMPE, KEVIN M. LEWIS & BRYAN L. ADKINS, CONG. RSCH. SERV., R46379, EMERGENCY AUTHORITIES UNDER THE NATIONAL EMERGENCIES ACT, STAFFORD ACT, AND PUBLIC HEALTH SERVICE ACT 1, 1 (2020), https://sgp.fas.org/crs/natsec/R46379.pdf.

90. Exec. Order No. 13,951, 85 Fed. Reg. 62,179 (Sept. 24, 2020), https://www.govinfo.gov/content/pkg/DCPD-202000722/pdf/DCPD-202000722.pdf; Katie Keith, *Administration Health Care Executive Order*, HEALTH AFFAIRS BLOG (Sept. 24, 2020), https://www.healthaffairs.org/do/10.1377/hblog20200925.542259/full/.

91. ELSEA ET AL., *supra* note 89, at 1.

92. *Id.* at 3–4.

93. *Legal Authority of the Secretary*, U.S. DEP'T HEALTH & HUM. SERVS. (Sept. 5, 2019), https://www.phe.gov/Preparedness/support/secauthority/Pages/default.aspx.

94. *See generally* Public Health Service Act, Pub. L. No. 78-410, 58 Stat. 682 (1944); U.S. DEP'T OF HEALTH & HUM. SERVS., *supra* note 50.

95. Public Readiness and Emergency Preparedness Act, Pub. L. No. 109-148, 119 Stat. 2818, 2818 (2005); *Public Readiness and Emergency Preparedness Act*, U.S. DEP'T HEALTH & HUM. SERVS. (Dec. 9, 2020), https://www.phe.gov/Preparedness/legal/prepact/Pages/default.aspx.

96. 42 U.S.C. § 1320b–5; *1135 Waivers*, U.S. DEP'T HEALTH & HUM. SERVS. (Oct. 16, 2020), https://www.phe.gov/Preparedness/legal/Pages/1135-waivers.aspx.

oterrorism"[97] and other emergencies such as natural disasters and pandemics.[98]

2. Legal Epidemiology

Legal epidemiology, or "the scientific study and deployment of law as a factor in the cause, distribution, and prevention of disease and injury in a population,"[99] is an increasingly utilized tool that helps practitioners better understand the impact of laws on public health outcomes, or how laws act as social determinants of health.[100] This growing field recognizes that there is deep benefit to "generating, analyzing, and communicating information about law through quantitative and qualitative analysis,"[101] which can help avoid a common lawmaking pitfall to enact laws without seeing the desired results.[102]

There are three general components of legal epidemiology: legal prevention and control; legal etiology; and policy surveillance.[103] Legal prevention and control refers to how laws can be applied as interventions to prevent disease and injury or improve public health administration.[104] Examples of this method include systematic reviews of how the public responds (positively or negatively) to public health laws such as those related to alcohol or motor vehicles, which can then be used by policymakers and public health officials to fine tune the law.[105]

97. *Stockpile Responses*, U.S. DEP'T HEALTH & HUM. SERVS. (Dec. 17, 2020), https://www.phe.gov/about/sns/Pages/responses.aspx.

98. *See id.*; *see also* G. JAMES HERRERA & FRANK GOTTRON, CONG. RSCH. SERV., IF11574, NATIONAL STOCKPILES: BACKGROUND AND ISSUES FOR CONGRESS (2020), https://www.everycrsreport.com/files/2020-06-15_IF11574_34048030b07862881aec3105502e776d293680ca.pdf (describing the Strategic National Stockpile and other stockpiles).

99. Scott Burris, Lindsay K. Cloud, & Matthew Penn, *The Growing Field of Legal Epidemiology*, 26 J. PUB. HEALTH MGMT. & PRACTICE S4, S4 (2020), https://journals.lww.com/jphmp/Fulltext/2020/03001/The_Growing_Field_of_Legal_Epidemiology.2.aspx.

100. Betsy L. Thompson, Lindsay K. Cloud & Lance Gable, *Advancing Legal Epidemiology: An Introduction*, 26 J. PUB. HEALTH MGMT. & PRACTICE S1, S1 (2020), https://journals.lww.com/jphmp/Fulltext/2020/03001/Advancing_Legal_Epidemiology__An_Introduction.1.aspx.

101. *The Legal Epidemiology Competency Model Version 1.0*, U.S. CTRS. FOR DISEASE CONTROL & PREVENTION 2, https://www.cdc.gov/phlp/docs/menu-legalepimodel.pdf (last visited Feb. 15, 2022).

102. *See id.* at 2.

103. Scott Burris, Marice Ashe, Donna Levin, Matthew Penn & Michelle Larkin, *A Transdisciplinary Approach to Public Health Law: The Emerging Practice of Legal Epidemiology*, 37 ANN. REV. PUB. HEALTH 135, 139 (2016), https://www.annualreviews.org/doi/pdf/10.1146/annurev-publhealth-032315-021841.

104. *Id.*

105. *Id.*

Legal etiology refers to the study of laws as causes of disease and injury.[106] While many laws are "proposed, enacted, and enforced with little or no thought to health,"[107] laws and policies often have impacts on health across the population.[108] For example, a local jurisdiction's zoning laws could impact how citizens can access grocery stores; zoning that fails to account for food access in residential areas can lead to food deserts and diseases related to inadequate nutrition.[109] Because health can be impacted by laws that are not necessarily health-focused, a "health in all policies" approach leveraging "health impact assessments" could help ensure that laws are applied in a manner that preserves and promotes public health.[110] This approach assumes that every policy could impact public health and should receive an impartial assessment of what this impact could look like.[111]

Traditional policymaking tends to focus on the passage and implementation of a law or regulation, with less attention placed towards the effects of the law or regulation. Policy surveillance, or the "ongoing systematic, scientific collection and analysis of laws of public health significance,"[112] aims to provide a structured approach to determining how laws impact health outcomes. This process, rooted in both public health and legal research methodologies, attempts to uncover whether laws actually work over time.[113]

Policy surveillance has been used to study a wide range of initiatives aimed at shaping health outcomes. For example, policy surveillance was used to assess laws impacting tobacco, alcohol, and school-based nutrition and physical education,[114] as well as electronic health information, prescription drug abuse, and state coroner or medical examiner systems.[115] By tracking these laws over time, policymakers and other stakeholders can better monitor the public health legal

106. *Id.*

107. *Id.* at 140.

108. *Id.*

109. *Id.*

110. *Id.*

111. *See id.*

112. Scott Burris, Laura Hitchcock, Jennifer Ibrahim, Matthew Penn & Tara Ramanathan, *Policy Surveillance: A Vital Public Health Practice Comes of Age*, 41 J. HEALTH POL., POL'Y, & L. 1151, 1152 (2016), https://pubmed.ncbi.nlm.nih.gov/27531941/.

113. *Id.*

114. Ross C. Brownson, Jamie F. Chriqui, & Katherine A. Stamatakis, *Understanding Evidence-Based Public Health Policy*, 99 AM. J. PUB. HEALTH 1576, 1580 (2009), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2724448/pdf/1576.pdf.

115. Burris et al., *supra* note 112, at 1156.

landscape, identify areas for improving public health laws, and use creative approaches to address legal gaps impacting public health.[116]

Since the COVID-19 pandemic, policy surveillance has been focused on assessing the myriad aspects of laws and regulations related to the public health emergency. One example of this is the Center for Public Health Law Research at Temple University, which has a series of policy surveillance tools and datasets tracking laws related to the public health emergency.[117]

3. Misinformation, Disinformation, and Trust in Public Health

Throughout the COVID-19 pandemic, valid information related to the public health emergency has been intertwined with false information. Although this phenomenon is not unique to the COVID-19 pandemic or to public health, misinformation (*i.e.*, "false information shared by people who do not intend to mislead others")[118] and disinformation (*i.e.*, "false information deliberately created and disseminated with malicious intent")[119] can lead to a decrease in trust in public health, which in turn can lead to poorer health outcomes.[120] In the case of COVID-19, misinformation and disinformation related to vaccines has led to suboptimal inoculation rates, preventing herd immunity from taking place and prolonging the pandemic.

Countering misinformation and disinformation is a challenging endeavor that is ongoing.[121] False information spreads quickly, in part because the information does not need to be vetted before sharing.[122] Often, the false information stokes our fears and our negative inclinations, making the information more salient and memorable compared to valid information that may be objective but otherwise un-

116. *Id.* at 1155.

117. *Sentinel Surveillance of Emerging Laws Limiting Public Health Emergency Orders*, CTR. FOR PUB. HEALTH L. RSCH. (Dec. 2, 2021), https://phlr.org/product/sentinel-surveillance-emerging-laws-limiting-public-health-emergency-orders.

118. *How to Address COVID-19 Vaccine Misinformation*, U.S. CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/vaccines/covid-19/health-departments/addressing-vaccine-misinformation.html (last visited Feb. 15, 2022).

119. *Id.*

120. *Id.*

121. *See, e.g.*, *Countering Misinformation About COVID-19*, WORLD HEALTH ORG. (May 11, 2020), https://www.who.int/news-room/feature-stories/detail/countering-misinformation-about-covid-19.

122. *See* Edmund L. Andrews, *How Fake News Spreads Like a Real Virus*, STANFORD U. (Oct. 9, 2019), https://engineering.stanford.edu/magazine/article/how-fake-news-spreads-real-virus.

noteworthy.[123] Throughout the pandemic, the spread of misinformation and disinformation has created a so-called "infodemic," which poses a serious threat by "amplifying hate speech; heightening the risk of conflict, violence and human rights violations; and threatening long-terms prospects for advancing democracy, human rights and social cohesion."[124]

Attorneys and those working in the legal system and public health infrastructure have a special duty to promote valid, trustworthy information and to eliminate or mitigate misinformation and disinformation.[125] Arming clients with tools to counter the spread of false information is important for attorneys in every sector. For example, tort law protections (*e.g.*, intentional infliction of emotional distress and defamation), cyber-stalking laws (*e.g.*, 18 U.S.C. § 2261A), and fraud laws can be used as litigation swords against false information.[126] In addition, attorneys can promote the creation of and compliance with laws that prevent false information from being spread through artificial intelligence, as well as making certain social media data collection and storage methods more transparent.[127] In turn, public health practitioners can seek to understand the laws governing misinformation and disinformation and use those laws to combat stakeholders diluting and misconstruing critical factual information, whether deliberate or inadvertent.

4. Racism as a Public Health Issue

The longstanding effects of racism on public health outcomes have become clearer to policymakers in recent years.[128] According to one study, as of October 1, 2020, there were 128 resolutions, declarations, or bills addressing racism as a public health crisis that had been

123. *See id.*

124. *Managing the COVID-19 Infodemic: Promoting Healthy Behaviours and Mitigating the Harm From Misinformation and Disinformation*, WORLD HEALTH ORG. (Sept. 23, 2020), https://www.who.int/news/item/23-09-2020-managing-the-covid-19-infodemic-promoting-healthy-behaviours-and-mitigating-the-harm-from-misinformation-and-disinformation.

125. *See, e.g.*, *Legal Responses to Disinformation*, INT'L CTR. FOR NOT-FOR-PROFIT L., https://www.icnl.org/wp-content/uploads/2021.03-Disinformation-Policy-Prospectus-final.pdf (last visited Feb. 15, 2022).

126. *Id.*

127. *See id.*

128. *See* Lilliann Paine, Patanjali de la Rocha, Antonia P. Eyssallenne, Courtni Alexis Andrews, Leanne Loo, Camara Phyllis Jones, Anne Marie Collins & Michelle Morse, *Declaring Racism a Public Health Crisis in the United States: Cure, Poison, or Both?*, 9 FRONTIERS PUB. HEALTH 1, 1–4 (2021), https://www.frontiersin.org/articles/10.3389/fpubh.2021.676784/full.

passed by state and local governments.[129] These laws and declarations largely centered on the impact of systemic racism, COVID-19, social determinants of health, and specific health outcomes on Black communities, although several also included language addressing the inequities faced by Indigenous and Latinx communities.[130] While these laws and declarations are an important first step in acknowledging a widespread issue that has festered for generations, they have generally been vague (*i.e.*, they have largely neglected including action steps or appropriations of funding) and have, in some instances, undermined grassroots efforts while politicizing the issues.[131]

Further, structural racism persists as a factor in preventing optimal public health outcomes.[132] Structural racism refers to the "totality of ways in which societies foster racial discrimination through mutually reinforcing systems of housing, education, employment, earnings, benefits, credit, media, health care, and criminal justice. These patterns and practices in turn reinforce discriminatory beliefs, values, and the distribution of resources."[133] Public health data does not yet fully capture measures of structural racism, which in turn makes policymaking and public health programmatic efforts less robust.[134]

Discrimination, including racism, is a foundational SDOH that can restrict access to the very resources and opportunities necessary to increase health equity,[135] exacerbating disparities in myriad health outcomes ranging from maternal death,[136] to diabetes.[137] As more discussions take place around the role of racism as a public health

129. Dara D. Mendez, Jewel Scott, Linda Adodoadji, Christina Toval, Monica McNeil & Mahima Sindhu, *Racism as Public Health Crisis: Assessment and Review of Municipal Declarations and Resolutions Across the United States*, 9 FRONTIERS PUB. HEALTH 1, 3 (2021), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8385329/.

130. *Id.* at 9.

131. *Id.*; Paine et al., *supra* note 128, at 1.

132. Rachel R. Hardeman, Patricia A. Homan, Tongtan Chantarat, Brigette A. Davis & Tyson H. Brown, *Improving the Measurement of Structural Racism to Achieve Antiracist Health Policy*, 41 HEALTH AFFS. 179, 184 (2022).

133. *Id.* at 179.

134. *Id.* at 183.

135. Brigette A. Davis, *Discrimination: A Social Determinant of Health Inequities*, HEALTH AFFS.: FOREFRONT (Feb. 25, 2020), https://www.healthaffairs.org/do/10.1377/forefront.20200220.518458/full/.

136. *Systemic Racism, a Key Risk Factor for Maternal Death and Illness*, NAT'L HEART, LUNG, & BLOOD INST. (Apr. 26, 2021), https://www.nhlbi.nih.gov/news/2021/systemic-racism-key-risk-factor-maternal-death-and-illness.

137. *See* Rebekah J. Walker, Joni Strom Williams & Leonard E. Egede, *Influence of Race/Ethnicity and Social Determinants of Health on Diabetes Outcomes*, 351 AM. J. MED. SCIS. 366 (2016).

issue, it is important for healthcare attorneys to stay updated on efforts made by state and local governments to better address the harmful impacts of racism on public health. In so doing, attorneys can better assist their clients across the broader healthcare system by taking initiative to address racism and promote health equity.

Conversely, it is critical that public health practitioners view law as an effective tool for addressing and dismantling racist systems and ensuring that all populations receive equitable resources and opportunities to achieve health and wellbeing. Putting this tool to good use requires a clear understanding of the protections offered by current laws as well as cross-sector collaboration with policymakers to inform the creation of new laws or expansion of existing laws to increase their efficacy in creating conditions for health equity.

IV. ADVANCING HEALTH OUTCOMES AND EQUITY BY COMPLYING WITH PUBLIC HEALTH LAWS

Longstanding disparities in healthcare access, care delivery, and patient outcomes were exacerbated by the COVID-19 pandemic.[138] Despite being a completely novel virus, certain populations—such as Black, Hispanic, elderly, low-income, and rural populations—fared significantly worse during the pandemic compared to others.[139] For example, vaccine coverage was lower in rural areas compared to suburban and urban areas, and was also lower for Black and Hispanic individuals compared to White individuals.[140] Testing availability was also lower for rural and low-income areas, in addition to communities of racial and ethnic minority populations.[141] While these disparities are multifactorial in nature, the racial and socioeconomic inequities that have occurred throughout the COVID-19 pandemic underscore a drastic need for both the public health and legal sectors to take action.[142] With health equity (*i.e.*, "the state in which everyone has a fair and just opportunity to attain their highest level of health")[143] being a

138. *See* Elizabeth Ann Andraska, Olamide Alabi, Chelsea Dorsey, Young Erben, Gabriela Velazquez, Camila Franco-Mesa, & Ulka Sachdev, *Health Care Disparities During the COVID-19 Pandemic*, 34 SEMINARS VASCULAR SURGERY 82, 87 (2021).

139. *Id.* at 83–85.

140. Sarah A. Lister, Hassan Z. Sheikh, & Taylor R. Wyatt, CONG. RSCH. SERV. R46861, Health Equity and Disparities During the COVID-19 Pandemic: Brief Overview of the Federal Role 1, 5–6 (2021).

141. *Id.* at 5.

142. Andraska et al., *supra* note 138, at 82, 84.

143. *What Is Health Equity?* U.S. CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/healthequity/index.html (last visited Feb. 15, 2022).

nexus point for reflection and action, improving health equity is of paramount importance to address gaps in health outcomes across populations.[144] Here, we provide an overview of health equity initiatives across federal and state governments, as well as in the private sector.

A. Health Equity at the Federal Level

The first concerted efforts to identify and address health inequities at the federal level occurred in the 1980s. The 1985 Report of the Secretary's Task Force on Black and Minority Health—referred to as the "Heckler Report," named after HHS Secretary Margaret Heckler—gave Congress its first detailed picture of how racial and ethnic minority populations faced worse health outcomes compared to White individuals.[145] Sensing that research and medical advancements were leading to longer lifespans and improved health for White populations but not others, the Heckler Report led to the creation of the Office of Minority Health in 1986, housed within HHS.[146] Other agencies within HHS have their own versions of the Office of Minority Health, including AHRQ, CDC, CMS, FDA, HRSA, NIH, and SAMHSA.[147] Thus, key federal health agencies are equipped to collect information on disparate health outcomes across populations, translate that information into actionable goals for improving health outcomes, and spearhead future initiatives to promote health equity.[148] Federal agencies including those across HHS continue to explore and expand their commitment to health equity, such as the CDC's nascent CORE Commitment to Health Equity.[149]

Prior to the COVID-19 pandemic, there were several federal laws in place designed to prevent discrimination during public health emer-

144. Steven C. Martino, Sangeeta Ahluwalia, Jordan Harrison, Alice Kim & Marc N. Elliott, *Developing Health Equity Measures*, RAND HEALTH CARE (2021), https://aspe.hhs.gov/sites/default/files/private/pdf/265566/developing-health-equity-measures.pdf.

145. Allan S. Noonan, Hector Eduardo Velasco-Mondragon & Fernando A. Wagner, *Improving the Health of African Americans in the USA: An Overdue Opportunity for Social Justice*, 37 PUB. HEALTH REV. 1–2 (2016).

146. *Id.*

147. *Offices of Minority Health at HHS*, U.S. DEP'T OF HEALTH AND HUM. SERVS., OFF. OF MINORITY HEALTH, https://www.minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=7 (last visited Feb. 15, 2022).

148. *See id.*

149. *CDC Core Health Equity Science and Intervention Strategy*, U.S. CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/healthequity/core/index.html (last visited Feb. 15, 2022).

gencies.[150] Specifically, the Civil Rights Act, Rehabilitation Act, Stafford Act, Homeland Security Act, Patient Protection and Affordable Care Act, Social Security Act, and Public Health Service Act each offered protections against discrimination in various forms.[151] As the pandemic took shape, it became clear that these laws were insufficient to prevent health disparities from occurring. New laws and policies were enacted to address the health disparities related to COVID-19, including the Coronavirus Preparedness and Response Supplemental Appropriations Act, the Families First Coronavirus Response Act, the Coronavirus Aid, Relief and Economic Security Act, the Paycheck Protection Program and Health Care Enhancement Act, the Coronavirus Response and Relief Supplemental Appropriations Act, and the American Rescue Plan Act.[152] In addition, the "Ensuring an Equitable Pandemic Response and Recovery" Executive Order, issued on January 21, 2021, created the COVID-19 Health Equity Task Force, housed within the HHS Office of Minority Health.[153] Lastly, vaccination access programs established by the Federal Emergency Management Agency and public health response strategies created by CDC have incorporated health equity to better address disparities in health outcomes.[154]

B. Health Equity at the State Level

States saw a flurry of health equity legislation between January 2020 and July 2021, with thirty-four states enacting health equity legislation during that timeframe.[155] These new laws indicate an acknowledgement amongst governments on a bipartisan level that health outcomes differ dramatically across subgroups of the population and can be addressed, at least in part, by government intervention.

Three states—Minnesota, California, and Florida—serve as poignant examples. The 2020 murder of George Floyd catalyzed discussions on race—including health equity—across the state and nationally.[156] The Minnesota Legislature enacted four laws targeting

150. Sarah A. Lister, et al., *supra* note 140, at 6–8.
151. *Id.*
152. *Id.* at 8.
153. *Id.* at 9.
154. *Id.* at 2.
155. *See Health Disparities Legislation*, NAT'L CONF. OF STATE LEGIS. (Aug. 13, 2021), https://www.ncsl.org/research/health/health-disparities-laws.aspx.
156. *See, e.g.*, Jason Laughlin & Erin McCarthy, *Thousands of Medical Workers Turn Out to Remember George Floyd and Work for Health Equity*, PHILA. INQUIRER (June 8, 2020), https://

health disparities amidst the backdrop of recognizing the racial inequities across the state.[157] These laws focused on leveraging electronic health record technology to reduce health disparities, increasing access to community health clinics, allocating grant money for pregnancy home visiting programs to improve inequities in maternal care, and considering health disparities when altering preferred drug lists.[158]

In California, the state legislature passed a law that created a "health equity dashboard" to better gauge how COVID-19 is impacting people based on race and ethnicity.[159] In addition, a law was passed earlier this year requiring the state's Department of Managed Care to convene a Health Equity and Quality Committee to create measures addressing health equity and quality.[160] Connecticut passed a similar law establishing a "Commission on Racial Equity in Public Health" that will address health equity issues across the state.[161]

Finally, in Florida, state data shows that racial and ethnic minority populations experience higher rates of illness and death for a wide range of health conditions, including heart disease, stroke, diabetes, HIV/AIDS, and maternal mortality.[162] In part built off of this troubling data, the state legislature passed a bill requiring the state's Office of Minority Health to create new programs and policies aimed at both informing the public about health disparities and also improving access to healthcare services for racial and ethnic minority populations.[163]

C. Health Equity at the Local Level

Local jurisdictions across the country have passed resolutions acknowledging the role that racism plays in creating health disparities, with many such resolutions specifying commitments to actions in-

www.inquirer.com/health/doctors-residents-white-coats-black-lives-philadelphia-demonstration-protest-20200605.html.

157. NAT'L CONF. OF STATE LEGIS., *supra* note 155.

158. *Id.*

159. *Id.*; *COVID-19 Age, Race and Ethnicity Data*, CAL. DEP'T OF PUB. HEALTH (Oct. 6, 2021), https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Race-Ethnicity.aspx#; *California's Commitment to Health Equity*, CAL. ALL (Feb. 17, 2021), https://covid19.ca.gov/equity/.

160. NAT'L CONF. OF STATE LEGIS., *supra* note 155.

161. *Id.*

162. *Health Equity Profile - 2020*, FLA.DEP'T OF PUB. HEALTH, https://www.flhealthcharts.gov/ChartsReports/rdPage.aspx?rdReport=ChartsProfiles.HealthEquityMergeMHProfile (last visited Feb. 15, 2022).

163. FLA. STAT. § 381.735 (2021).

tended to directly address these disparities. For example, in Wake County, North Carolina, a resolution declaring racism as a public health crisis includes language explicitly calling for the same urgency and funding to address racism as would be allocated to any other crisis; the language also includes commitments ranging from ensuring equitable personal protective equipment supply for high-need areas to addressing the infant mortality rate for infants of color.[164]

Some jurisdictions coupled their resolutions with local emergency powers, unlocking additional resources and authority. For example, Ohio counties including Akron, Cleveland and Summit "declared their resolutions emergency measures and tied this to establishing a Special Task Force (Akron), working group (Cleveland), or Special Review Committee (Summit)."[165] Policymaking at the local level, particularly when coupled with allocation of resources and funding, can be an opportunity for meaningful action for cities where the policy environment at the state level is unfavorable for public health action to address health disparities.

D. Health Equity at the Private Level

Beyond government-level interventions, private entities play an important role in promoting health equity. Private healthcare systems, insurers, businesses, non-profit organizations, and other stakeholders all make decisions that can perpetuate or mitigate health disparities. Thus, it is essential for health law practitioners to engage in identifying their clients' current actions that lead to disparate health outcomes, while promoting future actions that could improve health equity. Likewise, it is critical for public health practitioners to view private industry partners as true cross-sector collaborators to leverage change.

Health equity drives better healthcare for all who access the healthcare system.[166] This is a point that counsel for healthcare systems will be intimately familiar with, as health inequities are exposed

164. *See State and Local Efforts to Declare Racism a Public Health Crisis – Southeastern Region Update,* NETWORK FOR PUB. HEALTH LAW 1–2 (2021), https://www.networkforphl.org/wp-content/uploads/2021/05/State-and-Local-Efforts-to-Declare-Racism-a-Public-Health-Crisis-%E2%80%93-Southeastern-Region-Update-1.pdf.

165. *State and Local Efforts to Declare Racism a Public Health Crisis*, NETWORK. FOR PUB. HEALTH L. 1 (2020), https://www.networkforphl.org/wp-content/uploads/2020/06/State-and-Local-Efforts-to-Declare-Racism-a-Public-Health-Crisis-2.pdf.

166. Joni Strom Williams, Rebekah J. Walker & Leonard E. Egede, *Achieving Equity in an Evolving Healthcare System: Opportunities and Challenges*, 351 AM. J. MED. SCI. 33, 36 (2016).

through uncompensated care, hospital discharge procedures, "revolving door" patients, and expensive, complex medical cases stemming from untreated disease.[167] When historically disenfranchised groups receive equitable healthcare, those groups engage with the healthcare system earlier and more frequently, preventing high-cost treatment due to delays in seeking care.[168] Cost savings from improving health equity is an important metric for healthcare businesses. For example, a study by the University of Minnesota and Blue Cross Blue Shield of Minnesota found that health inequities cost the state $2.26 billion annually and led to more than 700 additional deaths;[169] improving health equity could slash these costs and improve health outcomes exponentially.

Cost savings from more equitable healthcare access can improve overall competitiveness of businesses and the national economy. When healthcare costs disproportionately impact certain groups of people experiencing health disparities, those same groups become prone to bankruptcy, absenteeism and presenteeism, and other negative consequences that impede ability to contribute to the workforce.[170] Additionally, large businesses are likely to have employees experience health disparities at similar rates to the general population.[171] Projections suggest that eliminating health disparities could add more than $350 billion back into the economy,[172] but will require sustained investment from the private sector.[173]

Lawyers have a unique position to promote health equity and justice. Because of their position, they are aptly situated to promote health equity by informing clients such as hospital system board mem-

167. *See* Geoffrey J. Hoffman, Charleen Hsuan, Thomas Braun & Ninez Ponce, *Health Equity and Hospital Readmissions: Does Inclusion of Patient Functional and Social Complexity Improve Predictiveness?*, 34 J. GEN. INTERNAL MED. 26, 27 (2019).

168. *See* Omolola E. Adepoju, Michael A. Preston & Gilbert Gonzales, *Health Care Disparities in the Post-Affordable Care Act Era*, 105 (Suppl. 5) AM. J. PUB. HEALTH S665, S665–66 (2015).

169. *Racism Is a Health Crisis: Make It Your Business*, BLUECROSS BLUESHIELD MINN., https://www.bluecrossmn.com/about-us/corporate-social-responsibility/health-equity (last visited Feb. 15, 2022).

170. *See* COMMUNITIES IN ACTION: PATHWAYS TO HEALTH, NAT. ACAD. OF SCI., ENG'G, AND MED. 391 (2017), https://www.nap.edu/read/24624/chapter/9#391.

171. Yele Aluko & Rachel Hall, *How Digital Technology Can Enable Health Equity and Enterprise Growth*, EY (Sept. 3, 2021), https://www.ey.com/en_us/health/health-equity-services/how-digital-technology-can-enable-health-equity.

172. *There's a Business Case for Health Equity and Companies Are All on the Hook to Achieve It, Says EY*, CIGNA, https://newsroom.cigna.com/buisness-case-for-health-equity-ey-research (last visited Feb. 15, 2022).

173. Aluko & Hall, *supra* note 171.

bers on health equity programs, advising healthcare staff on improving equitable care to patients, and preparing system settings for legal changes and administrative oversight related to improving health equity. Public-private partnerships, medico-legal clinics, and non-profit program initiatives focused on health equity can also be led or informed by lawyers. Importantly, legal professionals serving clients across the healthcare industry should understand the implications of health equity initiatives, which are still developing and integrating into common business and government practice. It is valuable to acknowledge those who take the lead in identifying, planning, and implementing health equity issues and programs; however those actions alone are not the goal. Although the increased attention towards health equity is encouraging, the ultimate goal is to attain equitable health for everyone, a goal that has not yet been fully realized.

E. Healthcare Inequities Within the LGBTQ Community

While there has been a rise of healthcare equity legislation within the States, there has been an even bigger push for healthcare inequity that disproportionately affects the LGBTQ community. More than 250 anti-LGBTQ bills have been introduced in state legislatures across the country in 2021, and additional bills are under consideration.[174] This discrepancy presents a notable issue in policy measures related to health equity, which can at once promote the health of the historically disenfranchised yet fall short in recognizing contemporary health inequities.[175]

Over half the states have introduced bills to curb the rights of transgender people.[176] These bills include provisions to block trans

174. *See* Wyatt Ronan, *2021 Slated to Become Worst Year for LGBTQ State Legislative Attacks as Unprecedented Number of States Poised to Enact Record-Shattering Number of Anti-LGBTQ Measures Into Law*, HUM. RTS. CAMPAIGN (Apr. 22, 2021), https://www.hrc.org/press-releases/2021-slated-to-become-worst-year-for-lgbtq-state-legislative-attacks.

175. *See id.*; *See also* Alphonso David, Press Release, HUM. RTS. CAMPAIGN, https://www.hrc.org/magazine/2021-spring/we-will-not-be-erased (last visited Feb. 26, 2022) ("[H]undreds of bills have been introduced in state legislatures around the country that attempt to erase transgender people [and] make LGBTQ people second class citizens. In order to achieve equality, we need those in positions of power at the largest businesses in the country to rise up against injustice and discrimination; businesses that have increasingly, over the years, embraced the inherent benefits of being socially responsible . . . . Companies cannot rise up and speak out against hate in the streets but remain silent when they see hate being indoctrinated in our laws by state legislatures and in the halls of the U.S. Capitol.").

176. Priya Krishnakumar, *This Record-Breaking Year for Anti-Transgender Legislation Would Affect Minors the Most*, CNN (Apr. 15, 2021, 9:46 AM), https://www.cnn.com/2021/04/15/politics/anti-transgender-legislation-2021/index.html.

student athletes from playing sports, as well as language that would prevent the transgender community from accessing medical care.[177] These bills are generally seen as "proactive" by proponents, while detractors claim that the legislation would only cause undue harm because the issues involved (*i.e.*, unfair advantages in sports and irreversible medical harm) are extremely rare.[178]

Several states serve as useful examples to illustrate anti-transgender legislation. In 2022, the state of Alabama introduced a bill that targets the transgender community and prohibits medical procedures and hormone replacement therapy for minors who elect to transition.[179] The bill proposes fines and possible criminal punishment for allowing minors of any age to undergo a medical transition from their assigned sex at birth to the one in which they identify with, even if there is approval from parents and medical professionals.[180] The bill states that its reasoning is because those that undergo cross-sex surgical procedures are at a higher risk of mortality than the general population, despite a lack of data from medical professionals.[181]

In Kentucky, a proposed bill prohibits any transition related procedures and hormone replacement therapy for those under the age of eighteen.[182] The bill prohibits healthcare services under state or local government to include gender related procedures and would prohibit public funding and tax deductions for such treatments.[183]

A similar bill was passed in Oklahoma, which makes it unlawful for any transgender identifying individual to alter primary or secondary sex characteristics which include gender affirming surgeries and hormone replacement therapy.[184] The bill makes it unlawful for healthcare professionals to treat those within the transgender community who are under the age of twenty-one while imposing a $20,000 fine and a minimum of three years imprisonment for violations.[185]

The state of Tennessee has introduced more than seventy pieces of anti-LGBTQ legislation in recent sessions.[186] The state passed a

177. *See id.*
178. *See id.*
179. S. 184, 2022 S.B., Reg. Sess. (Ala. 2022).
180. *Id.*
181. *Id.*
182. S. 84, 2022 S.B., Reg. Sess. (Ky. 2022).
183. *Id.*
184. S. 676, 2021 S.B., Prior Sess. (Okla. 2021).
185. *Id.*
186. Wyatt Ronan, *2021 Slated to Become Worst Year for LGBTQ State Legislative Attacks as Unprecedented Number of States Poised to Enact Record-Shattering Number of Anti-LGBTQ*

controversial "business bathroom bill," which would require businesses to advertise restrooms designated for use by either biological sex.[187] In addition, a law was enacted banning hormone therapy for the purposes of treating minors with gender dysphoria, thus preventing transgender youth from being able to access best-practice, age-appropriate, medically-necessary gender affirming care.[188] Tennessee law also bars transgender youth from playing sports, and two additional laws have been enacted that prevent transgender students from being able to use a gender affirming restroom or locker room at school,[189] and another which would place certain limits on how discussion of LGBTQ people, sexuality, or gender occurs in classroom settings.[190]

Texas has also enacted several bills that are broadly considered to be anti-LGBTQ.[191] For example, a new law restricts transgender student athletes' ability to participate on sports teams,[192] and executive policy decisions criminalize aspects of seeking gender-affirming medical care.[193] These policy positions would classify gender-affirming care as child abuse — which can be classified as a felony with corresponding jail time.[194]

Medical standards for transgender patients, such as those promoted by the World Professional Association for Transgender Health (WPATH),[195] should be considered by attorneys representing clients who are dealing with health inequities related to anti-transgender laws. These standards of care are based on the best available medical

Measures Into Law, HUM. RTS. CAMPAIGN (Apr. 22, 2021), https://www.hrc.org/press-releases/2021-slated-to-become-worst-year-for-lgbtq-state-legislative-attacks.

187. TENN. CODE ANN. § 68-120-120; Laken Brooks, *How Tennessee's Transgender Business Bathroom Bill Poses a Major Health Risk*, FORBES (May 30, 2021, 1:40 AM), https://www.forbes.com/sites/lakenbrooks/2021/05/30/how-tennessees-transgender-business-bathroom-bill-poses-a-major-health-risk/?sh=48e75bc33572.

188. TENN. CODE ANN. § 63-1-169.

189. TENN. CODE ANN. §§ 49-2-801–05.

190. TENN. CODE ANN. § 49-6-1308.

191. *See, e.g.*, Rina Torchinsky, *In Texas, an Unrelenting Assault on Trans Rights is Taking a Mental Toll*, NPR (Feb. 25, 2022, 3:30 PM), https://www.npr.org/2022/02/25/1082975946/anti-trans-bills-texas.

192. TEX. EDUC. CODE ANN. § 33.0834 (West 2022).

193. *See* Letter from Greg Abbott, Governor, State of Tex., to Honorable Jaime Masters, Comm'r, Tex. Dep't Fam. & Protective Serv.'s (Feb. 22, 2022), https://gov.texas.gov/uploads/files/press/O-MastersJaime202202221358.pdf.

194. *Id.*

195. Eli Coleman, Walter Bockting, Marsha Botzer, Peggy Cohen-Kettenis, Griet DeCuypere, Jaime Feldman, Lin Fraser, Jamison Green, Gail Knudson, Walter Meyer & Stan Monstrey, *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People*, THE WORLD PRO. ASS'N FOR TRANSGENDER HEALTH, Vol. 7 (2012).

evidence and are used by physicians and insurance providers that cover transition related care for those within the transgender community.[196] These standards of care may also be used by individuals, their families, and social institutions to understand how they can assist with promoting optimal health for members of this diverse population.

Despite efforts by states and other stakeholders to address health equity, anti-LGBTQ legislation is leading to additional inequities in healthcare access and quality. Further inclusion and destigmatization initiatives, as opposed to prohibitive legislation, could advance healthcare outcomes and reduce accessibility issues for this population and the general population alike.

V. CHANGES IN PUBLIC HEALTH AUTHORITY SINCE COVID-19

Finally, we provide examples of changes in state public health authority since COVID-19. As states look to either bolster or limit public health powers, healthcare attorneys should stay current on their jurisdiction's changes in order to provide timely and accurate counsel to a diverse array of clientele.

The politicization of the COVID-19 pandemic has led to political decisions that directly alter how public health responds to emergencies.[197] In the majority of states, public health authority has been curtailed since COVID-19.[198] A recent legislative review has shown that twenty-six states have passed laws that permanently weaken state and local public health authorities; executive orders, ballot initiatives, and state supreme court rulings have also limited the capabilities of public health authorities to respond to emergencies.[199]

Several examples highlight these changes. In Arkansas, a bill that prohibits state health officials from implementing mandatory face covering requirements and declares mask mandates as its own emergency was signed into law.[200] A sponsor of the bill was quoted, "It's time to

196. *Id.*; Flack v. Wisconsin Dep't of Health Servs., 395 F. Supp. 3d 1001, 1005 n.5 (W.D. Wis. 2019).

197. *See, e.g.*, Christopher Adolph, Kenya Amano, Bree Bang-Jensen, Nancy Fullman, Beatrice Magistro, Grace Reinke, Rachel Castellano, Megan Erickson & John Wilkerson, *The Pandemic Policy U-Turn: Partisanship, Public Health, and Race in Decisions to Ease COVID-19 Social Distancing Policies in the United States*, PERSPECTIVES ON POLITICS 1, 1, 9 (2021).

198. Lauren Weber & Anna Maria Barry-Jester, *Over Half of States Have Rolled Back Public Health Powers in Pandemic*, KAISER HEALTH NEWS (Sept. 15, 2021), https://khn.org/news/article/over-half-of-states-have-rolled-back-public-health-powers-in-pandemic/.

199. *Id.*

200. *Id.*

take the power away from the so-called experts, whose ideas have been woefully inadequate."[201] A similar bill in North Dakota was passed over the Governor's veto.[202] In Montana, laws were passed to limit isolation and quarantine powers, allow local elected officials to override local health officials' decisions, prohibit gathering restrictions, and prevent employers from requiring vaccinations for any condition.[203] In Ohio, a law was passed giving the state legislature the power to overturn public health orders.[204]

These examples underscore the discordance between state and federal laws. While many states have implemented laws undermining public health authority, the federal approach has been more proactive. Mask-wearing requirements remain in place for all domestic and international flights and transportation hubs,[205] and vaccination mandates for all federal employees,[206] as well as for businesses with more than 100 employees,[207] with the aim to increase the vaccination rate for a large swath of the country.

Attorneys representing hospitals, long-term care facilities, healthcare businesses, and other entities should keep tabs on state and federal actions related to public health authority. Clients from across healthcare and business settings will inevitably seek counsel to disentangle what is required of them to adhere to public health orders, whether those orders come from the state or the federal government. In such a situation, attorneys should evaluate whether any preemption exists between relevant laws.

VI. CONCLUSION

Healthcare attorneys who represent physicians, hospitals, health systems, and other healthcare partners are, arguably, also public health lawyers. Like public health lawyers, in order to effectively re-

201. *Id.*
202. *Id.*
203. *Id.*
204. *Id.*
205. *Order: Wearing of Face Masks While on Conveyances and at Transportation Hubs*, U.S. CTRS. FOR DISEASE CONTROL & PREVENTION (Feb. 25, 2022), https://www.cdc.gov/quarantine/masks/mask-travel-guidance.html.
206. *Executive Order on Requiring Coronavirus Disease 2019 Vaccination for Federal Employees*, WHITE HOUSE (Sept. 9, 2021), https://www.whitehouse.gov/briefing-room/presidential-actions/2021/09/09/executive-order-on-requiring-coronavirus-disease-2019-vaccination-for-federal-employees/.
207. Katie Rogers & Sheryl Gay Stolberg, *Biden Mandates Vaccines for Workers, Saying, 'Our Patience Is Wearing Thin'*, N.Y. TIMES (Sept. 9, 2021), https://www.nytimes.com/2021/09/09/us/politics/biden-mandates-vaccines.html.

present their clients, healthcare attorneys must be competent in the fundamentals of how our federalist system of government shapes public health infrastructure and creates the framework for public health emergency legal preparedness, response, and mitigation. This includes, as we've seen throughout the COVID-19 pandemic, the authority of governments to implement public health measures.

As discussed in this paper, modern healthcare attorneys should also have knowledge of laws related to public health surveillance, understand how legal epidemiology can be used to study the impact of law on health, and be prepared to use legal tools to address racism as a public health issue. The role of attorneys in advancing health outcomes and reducing racial health disparities cannot be understated. The challenge for 21st century healthcare attorneys, across practice areas, is to find innovative ways to integrate public health principles and health equity considerations across governance, workforce, and care delivery. This paper aims to provide a foundation to do just that.

Demographic Data and the Covid-19 Pandemic: A Regulatory Conundrum

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I. INTRODUCTION

The demand of public health officials and policymakers is often for "more data," but the quantity of data is not always as important as its granularity.[1] Understanding that 805,000 people have heart attacks

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1. Beth Blauer & Jennifer Nuzzo, *Covid-19 Data Is a Mess. We Need a Way to Make Sense of It*, N.Y. TIMES (Nov. 23, 2020), https://www.nytimes.com/2020/11/23/opinion/coronavirus-testing.html ("Covid-19 is surging and hospital capacity is being stretched. Disparities are deepen-

every year in the United States seems like an important piece of data[2]; however, it is unactionable unless coupled with additional data that reveals who those 805,000 people actually are.[3] Demographic data is one of the most powerful tools when crafting a public health response, as it allows health officials to understand more precisely who is impacted by disease. During the COVID-19 pandemic, "demographics" have often been understood as age, ethnicity, race, and sex/gender although demographic data encompasses a diverse array of characteristics by which to disaggregate a population: economic status, education level, political affiliation, and more.[4]

Each of these measures provides unique and powerful insight into disease and the societal structures that enable a pathogen to spread rapidly, disproportionately affecting certain communities. Age and sex data can help biomedical researchers better understand the mechanics of disease, as it is well-established that human biological differences can have dramatic impacts on immune response.[5] Better understanding of societal constructs – such as ethnicity, gender, and race – enables epidemiologists to design mitigation efforts and investigate the mechanics of viral transmission. Ethnicity and race are also at the core of understanding the components of society that prop up systemic racism and result in unacceptable health disparities. Demo-

ing, with Black and Latino patients more likely to be hospitalized and die from Covid-19. As the pandemic accelerates to new levels of transmission every day, we urgently need a federal standard to . . . inform public health responses."); Simret Aklilu, *DC's Mayor Urges More Coronavirus Data Collection in Communities of Color*, CNN (Apr. 12, 2020), https://www.cnn.com/2020/04/12/politics/dc-mayor-coronavirus-testing-muriel-bowser-cnntv/index.html, ("Washington, DC, Mayor Muriel Bowser on Sunday said that there should be a national focus to collect data on coronavirus deaths in communities of color."); Mayor John Cooper, Twitter, @JohnCooper4Nash (June 4, 2020) ("Given the recent uptick in case numbers, we need more data to continue making well-informed public health decisions."), https://twitter.com/johncooper4nash/status/1268556609061629953; *see also* Ross C. Brownson, Jamie F. Chriqui & Katherin A. Stamatakis, *Understanding Evidence-Based Public Health Policy*, 99 AM. J. PUB. HEALTH 1576 (2009) (discussing use of data within health policymaking).

2. *Heart Disease Facts*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/heartdisease/facts.htm (last modified Sept. 27, 2021).

3. *Id.* ("Heart disease is the leading cause of death for people of most racial and ethnic groups in the United States, including African American, American Indian, Alaska Native, Hispanic, and white men. For women from the Pacific Islands and Asian American, American Indian, Alaska Native, and Hispanic women, heart disease is second only to cancer.").

4. *Weekly Updates by Select Demographic and Geographic Characteristics: Provisional Death Counts for Coronavirus Disease 2019 (COVID-19)*, U.S. CTRS. DISEASE CONTROL & PREVENTION, https://www.cdc.gov/nchs/nvss/vsrr/covid_weekly/index.htm (last modified Feb. 23, 2022); *Demographic Characteristics of People Receiving COVID-19 Vaccinations in the United States*, U.S. CTRS. DISEASE CONTROL & PREVENTION, https://covid.cdc.gov/covid-data-tracker/#vaccination-demographic (last modified Feb. 23, 2022).

5. Sabra L. Klein & Katie L. Flanagan, *Sex Differences in Immune Responses*, 16 NATURE REVS. IMMUNOLOGY 626, 627–32 (2016).

graphic data can and should help us improve as a society, reversing generations of divestment, taking care of the vulnerable, and prioritizing care for those most at-risk.[6]

These demographic categories represent just a fraction of what the public health community refers to as the "social determinants of health."[7] Social determinants of health are the aspects of a person's life outside of their immediate control that impact their health, well-being, and life expectancy.[8] For example, a family's strained economic status may lead to unmanageable stress and poor nutrition.[9] The COVID-19 pandemic has highlighted the impact of social determinants of health as they drive immense health disparities in the United States.[10] Detailed demographic data allow us to better understand the root causes of these inequities, highlight widespread failures of our public health systems, and design targeted and lasting solutions.

Granular demographic data has the potential to dramatically empower public health officials, medical providers, and policymakers to reverse generations of systemic failure. When we know who is most vulnerable to a disease, we can design more targeted strategies and deploy resources to help the affected recover and start mitigating further spread. Disease mechanics are much more apparent with data disaggregated by demographic, temporal, and spatial metrics. We can

6. *See, e.g.*, *Finding Most Vulnerable Communities to Erase Inequalities Depends on Strong Data, Secretary-General Tells Population and Development Commission at Session Opening*, UNITED NATIONS (Apr. 11, 2016), https://www.un.org/press/en/2016/pop1046.doc.htm ("The 2030 Agenda was built on the assumption that every country would be able to identify and locate the most vulnerable people, to identify interventions that resulted in the greatest improvements in their welfare and to monitor progress.").

7. *Social Determinants of Health*, HEALTHY PEOPLE 2030, https://health.gov/healthypeople/objectives-and-data/social-determinants-health (last visited Nov. 15, 2021).

8. *Id.* ("Social determinants of health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.").

9. *E.g.*, Fred C. Pampel, Patrick M. Krueger & Justin T. Denney, *Socioeconomic Disparities in Health Behaviors*, 36 ANN. REV. SOCIO. 349, 361 (2010); Nicole Darmon & Adam Drewnowski, *Does Social Class Predict Diet Quality*, 87 AM. J. CLINICAL NUTRITION 1107 (2008) ("Diet quality is affected not only by age and sex, but also by occupation, education, and income levels – the conventional indexes of socioeconomic status."); Carol Graham, *The High Costs of Being Poor in America: Stress, Pain, and Worry*, BROOKINGS (Feb. 19, 2015), https://www.brookings.edu/blog/social-mobility-memos/2015/02/19/the-high-costs-of-being-poor-in-america-stress-pain-and-worry/.

10. *See* Tara L. Upshaw, Chloe Brown, Robert Smith, Melissa Perri, Carolyn Ziegler & Andrew D. Pinto, *Social Determinants of COVID-19 Incidence and Outcomes: A Rapid Review*, PLOS ONE (Mar. 31, 2021), doi.org/10.1371/journal.pone.0248336; Elissa M. Abrams & Stanley J. Szefler, *COVID-19 and the Impact of Social Determinants of Health*, 8 LANCET RESPIRATORY MED. 659, 660 (2020) ("The interplay of social determinants, asthma, and COVID-19 might help explain the risk of COVID-19 morbidity imposed by asthma, such as the disproportionate hospitalizations for COVID-19 among adults with asthma living in the USA.").

ensure that resources are used more efficiently — shipping tests, vaccines, and personal protective equipment ("PPE") to the areas that need them most. These data also allow for tailored communications and public health strategies that build public trust instead of shaking public confidence. Demographic data reveal health disparities,[11] identifying areas of need for policymakers to address.

Any in-depth investigation of social determinants of health should consider how to enact change, targeting policymakers to take action and address systemic inequalities that lead to egregious and persistent health disparities.[12] Even though the data community has been consistent in its pleas for better data throughout this crisis, the federal government has not instituted data standards, and many states fail to collect and interpret demographic data.[13] Legal and policy changes should support demographic data collection and the implementation of directed public health responses to aid those at greatest risk in our communities.

First, we will review the historical treatment and use of demographic data in the United States before establishing the critical importance of demographic data for the ongoing COVID-19 pandemic response. Demographic data have often been relegated to the census, minimizing our ability to understand and address the social determinants of health. This problem has only been exacerbated by the COVID-19 pandemic, as health disparities worsen along demographic lines. Then, we will summarize the demographic data that have been available throughout the pandemic and explain why standardization and better collection of demographic data have great potential to enable more effective public health responses to the current pandemic and future health crises. We believe that policy is necessary to ensure that data are collected in a manner that respects and reflects the diver-

11. *See Disparities*, HEALTHYPEOPLE.GOV, https://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities (last visited Nov. 15, 2021) ("If a health outcome is seen to a greater or lesser extent between populations, there is a disparity. Race and ethnicity, sex, sexual identity, age, disability, socioeconomic status, and geographic location all contribute to an individual's ability to achieve good health.").

12. SOC. DETERMINANTS OF HEALTH 4–5 (Michael Marmot & Richard Wilkinson, eds. 2d ed. 2006) ("An explicit intention of *The solid facts* and this book is to give definition to the social determinants of health – to unpack the social environment – in order to be more precise about areas of policy making. . . . Good social policy will pay attention to these social determinants at the same time as further research will do much to clarify the nature of their relationships to health.").

13. Beth Blauer, *We Need a Daily Data Dump*, JOHNS HOPKINS CORONAVIRUS RES. CTR.: PANDEMIC DATA INITIATIVE (June 7, 2021), https://coronavirus.jhu.edu/pandemic-data-initiative/data-outlook/we-need-a-daily-data-dump.

sity of this country. Policy change will have to couple with activism and local leadership to ensure data are used to enact lasting change that addresses demographic health disparities.

II. A PRE-PANDEMIC PICTURE OF DEMOGRAPHIC DATA

Demographic data has often been neglected or misused throughout the history of the United States, whether forming the basis for redlining housing policies or racist pseudoscience. When considering demographic data, the most complete and reliable source in the United States is often the census. The U.S. census has been administered every ten years since the American Revolution and seeks to provide a count of every person living in the country, often including additional information on demographics, geography, and economics.[14] Through 2010, the U.S. census primarily relied on paper forms and surveys, similar to how it was first administered in 1790.[15] After the 2010 census, which offered no digital response options, the U.S. Census Bureau began testing online response capabilities through the monthly American Community Survey.[16] The 2020 census then was administered as a combination of paper and online surveys, due in part to the lockdown protocols for the COVID-19 pandemic.[17] Despite more options than ever, the 2020 census response rate was estimated to be just 67% as of October 28, 2021.[18]

Despite the opportunity to collect high-quality demographic data, the 2020 census was not significantly expanded[19] due to political pressures from both sides of the aisle.[20] The final census only contained

14. *History*, U.S. CENSUS BUREAU, https://www.census.gov/history/www/census_then_now/ (last visited Feb. 24, 2022).

15. *Decennial Census of Population and Housing Questionnaires & Instructions*, U.S. CENSUS BUREAU, https://www.census.gov/programs-surveys/decennial-census/technical-documentation/questionnaires.2010_Census.html (last revised Nov. 23, 2021) (indicating census would be completed with pen and paper).

16. The American Community Survey collects data to supplement the decennial census. D'Vera Cohn, *Census Bureau Pushes Online Survey Response Option*, PEW RSCH. CTR. (Apr. 26, 2012), https://www.pewresearch.org/social-trends/2012/04/26/census-bureau-pushes-online-survey-response-option/.

17. *Census Bureau Announces Areas to Receive 2020 Census Paper Questionnaires First, and Areas to Receive Bilingual Invitations*, U.S. CENSUS BUREAU (Nov. 18, 2019), https://www.census.gov/newsroom/press-releases/2019/contact-strategies-viewer.html.

18. *Mapping Response Rates for a Fair and Accurate 2020 Census*, HTC 2020, https://www.censushardtocountmaps2020.us/ (last visited Feb. 20, 2022).

19. *Questions Planned for the 2020 Census and American Community Survey*, U.S. CENSUS BUREAU (Mar. 2018), https://www2.census.gov/library/publications/decennial/2020/operations/planned-questions-2020-acs.pdf.

20. Gregory Wallace, *2020 Census Mired in Political Controversy as Deadline Nears*, CNN POLS. (Sept. 9, 2020), https://edition.cnn.com/2020/09/09/politics/census-challenges/index.html.

nine questions, acquiring data on home ownership, age, sex, ethnicity, and race from all households.[21] There were no improvements over the data collection from 2010, which asked ten almost identical questions.[22] The data were initially released on August 12, 2021 as the restricted redistricting dataset before being released in full on September 30, 2021.[23] This experience highlights two major concerns with demographic data in the United States: delayed reporting and a lack of detail.

Some of the limitations of the census – particularly regarding the categorizations of race and ethnicity – arise due to standards mandated by the U.S. Office of Management and Budget.[24] These federally-set categories for race and ethnicity have not been updated since the Clinton Administration in 1997.[25] To this day, the only required race categorization options are: "American Indian or Alaska Native," "Asian," "Black or African American," "Native Hawaiian or Other Pacific Islander," and "White."[26] The one success of the 1997 review was the addition of the option to select multiple races,[27] accounting for the potential of intersectionality, although how that is reflected in data that are released is inconsistent at best. In fact, only slightly more than half of Americans believe that the demographic categorizations on the 2020 census were able to reflect their identity well.[28] De-

21. U.S. CENSUS BUREAU, 2020 CENSUS INFORMATIONAL BILINGUAL QUESTIONNAIRE, https://www2.census.gov/programs-surveys/decennial/2020/technical-documentation/questionnaires-and-instructions/questionnaires/2020-informational-questionnaire.pdf (last visited Feb. 24, 2022).

22. U.S. CENSUS BUREAU, *supra* note 14.

23. *2020 Census: Redistricting File (Public Law 94-171) Dataset*, U.S. CENSUS BUREAU (Aug. 12, 2021), https://www.census.gov/data/datasets/2020/dec/2020-census-redistricting-summary-file-dataset.html; *Census Bureau Statement on Redistricting Data Timeline*, U.S. CENSUS BUREAU (Feb. 12, 2021), https://www.census.gov/newsroom/press-releases/2021/statement-redistricting-data-timeline.html.

24. *Explanation of Data Standards for Race, Ethnicity, Sex, Primary Language, and Disability*, U.S. DEP'T HEALTH & HUMAN SERVS., OFF. OF MINORITY HEALTH, https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=3&lvlid=54 (last modified May 18, 2021, 3:41 PM).

25. *Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity*, FED. REG. (Oct. 30, 1997), https://www.federalregister.gov/documents/1997/10/30/97-28653/revisions-to-the-standards-for-the-classification-of-federal-data-on-race-and-ethnicity; *NIH Inclusion Outreach Toolkit*, *Office of Management and Budget (OMB) Standards*, NAT'L INST. OF HEALTH, (last visited Feb. 24, 2022), https://orwh.od.nih.gov/toolkit/other-relevant-federal-policies/OMB-standards.

26. U.S. DEP'T OF HEALTH & HUM. SERVS., *supra* note 24.

27. *Id*.

28. D'vera Cohn, Anna Brown & Mark Huog Lopez, *Black and Hispanic Americans See Their Origins as Central to Who They Are, Less So for White Adults*, PEW RSCH. CTR. (May 14, 2021), https://www.pewresearch.org/social-trends/2021/05/14/black-and-hispanic-americans-see-their-origins-as-central-to-who-they-are-less-so-for-white-adults/.

spite the inability of census categorizations to adequately capture the diversity of the United States and the ways different communities may experience public health issues, they would still be best if applied consistently nationwide. However, the scope of the Office of Management and Budget only includes surveys and data collection performed by the federal government,[29] leaving sub-national jurisdictions, frontline agencies, and community-based organizations to determine their own methodology for capturing race and ethnicity data.

The concept of federally-determined data standardization could be interpreted as imposing upon state autonomy and contradicting principles of limited federal power. However, it is also worth considering that the current situation – giving U.S. states the freedom to classify demographics however they prefer – greatly limits the ability of health experts to collect and analyze data in an actionable manner.[30] This, in turn, can perpetuate entrenched practices that negatively impact at-risk populations. For example, sex and gender data is limited to binary options for male/female in most cases even though it is well understood that sex and gender exist on spectra.[31] For some people, responses to sex questions and gender questions differ. Some states have added categories to demographic surveys that better reflect ssex and gender diversity within the LGBTQIA+ community,

29. *Statistical Programs & Standards*, OFF. OF MGMT. & BUDGET, https://www.whitehouse.gov/omb/information-regulatory-affairs/statistical-programs-standards (last visited Nov. 18, 2021); Beth Blauer, *Demographic Data Disarray Hurts COVID-19 Policies*, JOHNS HOPKINS CORONAVIRUS RES. CTR.: PANDEMIC DATA INITIATIVE (June 14, 2021), https://coronavirus.jhu.edu/pandemic-data-initiative/data-outlook/demographic-data-disarray-hurts-covid-19-policies. It should be noted that uneven reporting occurs even within federal block grant programs. *E.g.*, *Better Data Are Needed to Ensure HUD Block Grant Funds Reach Vulnerable Populations*, GOV'T ACCOUNTABILITY OFF. (Dec. 9, 2021), https://www.gao.gov/products/gao-22-104452 ("GAO recommends that HUD collect, analyze, and publish demographic data . . . on vulnerable populations who apply for and receive assistance. HUD did not agree or disagree with the recommendation but identified potential ways to collect data to assess how vulnerable populations are being served and the associated challenges.").

30. Beth Blauer, *Filling the Map of COVID-19 Demographic Data*, JOHNS HOPKINS CORONAVIRUS RES. CTR.: PANDEMIC DATA INITIATIVE (Sept. 20, 2021), https://coronavirus.jhu.edu/pandemic-data-initiative/data-outlook/filling-in-the-map-of-covid-19-demographic-data. Perhaps the greatest argument against the conceptual imposition of federal standards are the desperate pleas from governors and mayors throughout the nation for guidance about how to report and use pandemic data to help in their public health strategies. Over the last 20 months, the Johns Hopkins Coronavirus Resource Center has frequently been called upon by sub-national leaders who were seeking advice and counsel about data collection best practices.

31. Beth Blauer & Sabra Klein, *Determining Discrete Data Points from the Sex and Data Spectra*, JOHNS HOPKINS CORONAVIRUS RES. CTR.: PANDEMIC DATA INITIATIVE (Aug. 30, 2021), https://coronavirus.jhu.edu/pandemic-data-initiative/data-outlook/determining-discrete-data-points-from-the-sex-and-gender-spectra.

such as "Other," "Nonbinary," "Gender Fluid," and "Transgender."[32] Many states still only offer male and female options even though they may not be reflective of all the residents in that state and the needs of the LGBTQIA+ community. Only 21 states and Washington, D.C. currently allow nonbinary individuals to identify as such on official documents, with some of those states still requiring a court order at licensing offices.[33] The health needs of the transgender community and their biological response to disease are also distinct and severely understudied.[34] By not actively promoting data collection that identifies these people appropriately, science and medicine are limited in how they can work with and serve this community.

If states' selection of their own demographic categories potentially hinders public health efforts and compromises individuals' ability to self-identity, a federal solution may ultimately be needed. Having said that, the federal government has a somewhat obsolete and decaying data infrastructure.[35] For example, reporting of notifiable diseases to the U.S. Centers for Disease Control and Prevention

32. Blauer, *supra* note 30; Kai Jillson & Heather Shattuck-Heidorn, *The "Unknown" Side of State COVID-19 Gender/Sex Reporting* GENDERSCILAB (Apr. 28, 2021), https://www.genderscilab.org/blog/unknown-covid19-gendersex-reporting.

33. *Identity Document Law and Policies*, MOVEMENT ADVANCEMENT PROJECT, https://www.lgbtmap.org/equality-maps/identity_document_laws (last modified Feb. 15, 2022).

34. *See, e.g.*, Sabra L. Klein & Rosemary Morgan, *The Impact of Sex and Gender on Immunotherapy Outcomes*, 11 BIOLOGY SEX DIFFERENCES 24, 30 (2020) ("The intersection of sex and gender becomes even more complex when people of other genders, including transgender individuals, are considered. Transgender men and transgender women, for example, may change their hormonal status through surgery and/or drugs and hormone supplementation, which may lead to different detrimental health outcomes, including risk and incidence of venous thromboembolism, ischemic stroke, and myocardial infarction. Not only are transgender individuals underrepresented in immunotherapy studies but the effect of immunotherapy outcomes on transgender individuals is a grossly under researched area."); Darios Getahun, Rebecca Nash, W. Dana Flanders, Tisha C. Baird, Tracy A. Becessar-Culqui, Lee Cromwell, Enid Hunkeler, Timothy L. Lash, Andrea Millman, Virginia P. Quinn, Brandi Robinson, Douglas Roblin, Michael J. Silverberg, Joshua Safer, Jennifer Solivs, Vin Tangpricha & Michael Goodman, *Cross-Sex Hormones and Acute Cardiovascular Events in Transgender Persons*, 169 ANNALS INTERNAL MED. 205 (2018).

35. Of note, parts of the private sector now have incredibly sophisticated data collection processes and infrastructure. Amazon, Facebook, Google, and many other companies have been covertly and overtly collecting massive amounts of data about individuals throughout the world for years. These companies use their valuable, privately-controlled data sets for many purposes, including better targeting of advertisements and user experience research. *See, e.g.*, Jonathan Vanian, *Mark Zuckerberg's Metaverse May Be as Privacy Flawed as Facebook*, FORTUNE (Oct. 29, 2021, 4:50 PM), https://fortune.com/2021/10/29/mark-zuckerberg-metaverse-privacy-facebook-meta/; Kim Komando, *How to See Everything Google Tracks About You and Erase It*, USA TODAY (Apr. 1, 2021, 5:00 AM), https://www.usatoday.com/story/tech/columnist/komando/2021/04/01/google-tracks-lot-data-you-heres-how-erase-it/4811047001/; Jason Cohen, *Amazon's Alexa Collects More of Your Data than Any Other Smart Assistant*, PC MAG. (Oct. 22, 2021), https://www.pcmag.com/news/amazons-alexa-collects-more-of-your-data-than-any-other-smart-assistant.

("CDC") by local health providers involves a multi-page form for each patient.[36] This then must be uploaded to the state health department, and subsequently reformatted for transmission to the National Notifiable Diseases Surveillance System ("NNDSS").[37] The incredibly detailed data are then cleaned and de-identified before being shared with the appropriate division of the CDC.[38] This can lead to significant lag time, which is especially challenging during a pandemic like COVID-19.[39] In sum, the United States' infrastructure has always lacked sufficient capacity to collect, aggregate, and interpret demographic data. The COVID-19 pandemic has simply exacerbated the need to modernize and standardize this data infrastructure to provide more reliable and actionable data.

III. THE STATE OF PANDEMIC DATA

In lieu of an adequate federal response, state governments developed entirely new systems of data collection and reporting during the COVID-19 pandemic. These state and local governments did something remarkable over the past two years of the pandemic — they supported residents and improved safety in the midst of an unforeseen public health crisis.[40] Never before have states attempted to collect and disseminate such a large quantity of data in near real time, and many did so despite underfunded and understaffed health departments.[41] Statehouse teams were formed, new skills unearthed, and data use habits emerged in daily briefings, communications, press standups, and public dashboards.[42] Our state and local leaders were

36. Vanian, *supra* note 35; Komando, *supra* note 35; Cohen, *supra* note 35.

37. *How We Conduct Case Surveillance*, Ctrs. Disease Control & Prevention, https://www.cdc.gov/nndss/about/conduct.html (last modified Sept. 29, 2021).

38. *Id.*

39. *About CDC COVID-19 Data*, Ctrs. Disease Control & Prevention, https://www.cdc.gov/coronavirus/2019-ncov/covid-data/about-us-cases-deaths.html (last modified Sept. 7, 2021).

40. *E.g.,* Jess Kirchner, Jordan Hynes & Belle Cuneo, *The Data Gets It Done*, Nat'l Governors Ass'n (Nov. 24, 2021), https://www.nga.org/news/commentary/the-data-gets-it-done ("[B]y the end of 2020, all 50 states had created Covid-19 dashboards to track public health and emergency response data.").

41. *See How Covid-19 Data Is Changing the World: A Statistical Perspective*, United Nations: Comm. for the Coordination of Stat. Activities (2020), https://unstats.un.org/unsd/ccsa/documents/covid19-report-ccsa.pdf; *see generally* Kristina Kintziger, Kahler W. Stone, Meredith A. Jagger & Jennifer A. Horney, *The Impact of the COVID-19 Response on the Provision of Other Public Health Services in the U.S.: A Cross Sectional Study*, 16 PLOS One 1 (2021), https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0255844.

42. Beth Blauer, *Sharing Lessons from Pandemic Data Management with Congress*, Johns Hopkins Coronavirus Res. Ctr.: Pandemic Data Initiative (July 6, 2021), https://corona

required to make impossible choices to stall the spread of disease, making use of every opportunity from closing schools and businesses to mask and vaccine mandates. Before highly effective vaccines, these public policy decisions were the only tools we had to curb the most detrimental effects of COVID-19. This local decision-making was accomplished amidst unclear-at-best federal leadership, requiring each state and territory to determine its own methodology for collecting and reporting COVID-19 data.[43] Two years into the pandemic, the federal government has yet to provide strong data governance despite the pressures of this emergency.

Existing in some form since 1946, the CDC is the nation's public health agency, charged with protecting the United States from health safety and security threats, both foreign and domestic, regardless of severity or source.[44] The CDC's data collection, analysis, and information sharing have helped save countless lives from emerging diseases and other health risks, including chronic diseases, sexually transmitted diseases, and bioterrorism.[45] However, global health threats have expanded at a rate that the government's current data infrastructure cannot handle in real time, as has been demonstrated throughout the COVID-19 pandemic.[46]

The CDC relies on mainly optional case reporting of notifiable diseases by state, local, and territorial health departments (i.e., sub-national).[47] Jurisdictions across the United States benefit from providing data to the CDC, but rigorous data sharing was often abandoned with the rapidly evolving COVID-19 pandemic as health departments were stretched thin.[48] Data reporting was not a top priority when emergency rooms were overflowing. The data flow from sub-national health departments to the CDC NNDSS is complex, lengthy, and often experiences significant lag time.[49] This is highly

virus.jhu.edu/pandemic-data-initiative/data-outlook/sharing-lessons-from-pandemic-data-management-with-congress.

43. *Id.*

44. CTRS. FOR DISEASE CONTROL & PREVENTION, *supra* note 39.

45. *CDC Timeline*, CTRS. DISEASE CONTROL & PREVENTION, https://www.cdc.gov/museum/timeline/1940-1970.html (last modified Jan. 11, 2021).

46. Kate Elizabeth Queram, *Public Health Departments Need 80,000 New Employees. But That's Not Enough for Another Pandemic*, ROUTE FIFTY (Oct. 13, 2021), https://www.route-fifty.com/health-human-services/2021/10/80000-public-health-employees-needed/186077/.

47. *What Is Case Surveillance?,* CTRS. DISEASE CONTROL & PREVENTION, https://www.cdc.gov/nndss/about/index.html (last modified Sept. 29, 2021).

48. CTRS. DISEASE CONTROL & PREVENTION, *supra* note 37.

49. *CMS Releases Guidance on COVID-19 Data Reporting as a Condition of Hospitals' Medicare Participation,* AM. HOSPITAL ASS'N (Oct. 6, 2020), https://www.aha.org/news/headline/

disadvantageous when sub-national health departments acquiring data can publish it in real time without waiting for CDC dissemination.[50] Hence, state dashboards have been some of the best sources of data during the pandemic.

There exist legal questions as to the extent of the federal government's authority to set and enforce standards for sub-national data collection practices. There has, however, been success in tying data governance to funding mechanisms. In October 2020, the Centers for Medicare and Medicaid Services (CMS) announced that a new condition of participation in Medicare funding for hospitals would be standardized and frequent reporting of COVID-19 hospitalization data.[51] This decision placed an intense burden on hospitals, with the President and CEO of the American Hospital Association referring to the measure as "an overly heavy-handed approach that could jeopardize access to hospital care for all Americans."[52] The rollout of these standards put additional pressure on the strained American healthcare system, but providers rose to the challenge and hospitalization data was one of the most reliable and cleanest pandemic dataset available.[53]

Due to the lack of federal regulations and standards for other data streams, sub-national COVID-19 dashboards have varied greatly over the pandemic, particularly with regard to temporal, spatial, and content granularity.[54] Individual dashboards have also changed throughout the pandemic as resources are shifted or political leader-

2020-10-06-cms-releases-guidance-covid-19-data-reporting-condition-hospitals-medicare; Joshua E. Porterfield, *Q&A: Community Engagement Key to Data Collection and Dissemination*, JOHNS HOPKINS CORONAVIRUS RES. CTR. (Feb. 22, 2022), https://coronavirus.jhu.edu/pandemic-data-initiative/expert-insight/q-and-a-community-engagement-key-to-data-collection-and-dissemination; Beth Blauer, *Antiquated Data Infrastructure Delays Pandemic Reporting*, JOHNS HOPKINS CORONAVIRUS RES. CTR.: PANDEMIC DATA INITIATIVE (Jan. 18, 2022), https://coronavirus.jhu.edu/pandemic-data-initiative/data-outlook/antiquated-data-infrastructure-delays-pandemic-reporting.

50. CTRS. DISEASE CONTROL & PREVENTION, *supra* note 37.

51. AM. HOSP. ASS'N, *supra* note 49.

52. Rick Pollack, *AHA Statement on Interpretive Guidance on CMS Data Collection and Medicare Conditions of Participation Interim Final Rule*, AM. HOSP. ASS'N (Oct. 6, 2020), https://www.aha.org/press-releases/2020-10-06-aha-statement-interpretive-guidance-cms-data-collection.

53. Blauer, *supra* note 13.

54. *Covid-19 United States Map*, JOHNS HOPKINS CORONAVIRUS RES. CTR., https://coronavirus.jhu.edu/us-map (last visited Dec. 1, 2021) (It is important to note that state Covid-19 dashboards do not necessarily contain complete information, as they typically do not have access to data for U.S. Indian Health Services and U.S. Department of Veterans Affairs sites within their jurisdiction).

ship determines COVID-19 data is no longer a priority.[55] The data available on any singular dashboard have been liable to change from day to day in terms of breadth of content, quality, and frequency of updates.

Florida has been an interesting case study on the public availability of data throughout this crisis. Early in the pandemic, Florida was a model for availability of public data, providing line-level information on every case, including geographic, temporal, and demographic details every day.[56] This pinnacle of public service did not last, and the quality and timeliness of the data have been significantly reduced. As of February 2022, Florida now provides COVID-19 data updates just once per week, limiting the utility of the data for a public trying to make important personal decisions as the virus continues to rapidly spread.[57] The problem of reduced reporting is not limited to Florida. By June 2021, twenty-seven states and territories were no longer releasing updated COVID-19 case, death, and testing data on a daily basis.[58] That number had increased to thirty-seven states and territories, even with some states, such as Nebraska, restarting reporting efforts by spring 2022.[59]

The pandemic has made it clear that the American public has a thirst for accurate, real-time data to inform decisions ranging from travel to mitigation efforts when performing essential errands. When sub-national dashboards stop providing data, there may be a dearth of reliable sources. Even the CDC has suffered from confusion when state dashboards report information that conflicts with official reports from states to the CDC, which are filed separately.[60] The fault lies with both the federal government for failing to mandate that states

55. Press Release, Off. of Governor Pete Ricketts, Governor Ricketts Ends Coronavirus State of Emergency (June 28, 2021), https://governor.nebraska.gov/press/gov-ricketts-ends-coronavirus-state-emergency.

56. *Pandemic Data Initiative Expert Forum: Covid-19 Data Pioneers*, JOHNS HOPKINS CORONAVIRUS RES. CTR. (Nov. 12, 2021), https://coronavirus.jhu.edu/live/events/pandemic-data-initiative-expert-forum.

57. Brenda Argueta & Emilee Speck, *Florida Eliminates Some Covid-19 Data as State Averages 1,700+ New Cases Per Day*, CLICKORLANDO.COM (June 11, 2021, 7:05 PM), https://www.clickorlando.com/news/local/2021/06/11/florida-eliminates-some-covid-19-data-state-averages-1700-new-covid-19-cases-per-day/.

58. Blauer, *supra* note 13.

59. *State Reporting Frequencies*, JOHNS HOPKINS CORONAVIRUS RES. CTR., https://coronavirus.jhu.edu/data/state-reporting-frequencies (last visited Dec. 1, 2021).

60. Jane Musgrave, *Florida Accuses CDC of Inflating COVID Numbers in Apparent CDC Mistake*, PALM BEACH POST (Aug. 10, 2021), https://www.palmbeachpost.com/story/news/coronavirus/2021/08/10/florida-accuses-cdc-inflating-covid-numbers-cdc-changes-tally/5558411001/.

report data and the states themselves for failing to prioritize detailed data reporting as a service to their citizens.

As the pandemic has evolved, the number of COVID-related data streams has only increased. When vaccinations began rolling out in the United States in December 2020, states had to redesign their dashboards to include vaccination data, with some states even opting to produce a second, separate dashboard for vaccinations.[61] This decentralization of data has frequently resulted in inconsistencies within the same state health department's data due to different teams determining category labels and reporting frequency without adequate oversight.[62] Now there is greater interest in data on breakthrough cases as new SARS-CoV-2 variants of concern arise that may have greater abilities to overcome vaccination. As of September 2021, only thirty-five states provided public data on breakthrough cases.[63] Those thirty-five states also chose to report data in a variety of manners, from their COVID-19 dashboards to PDF reports to press releases, and even tweets.[64] Without consistency and centralization of data, the public finds it much more difficult to access, understand, and employ data in decision-making.

These data inconsistencies only serve to confuse the public and prevent public health specialists from gaining any useful national insight on the state of the pandemic. Comparison between states is critical when considering policy responses, yet it has become increasingly difficult to do. For example, many data aggregators have shifted to the use of 7-day moving averages for key data points to account for the fact that most sub-national jurisdictions no longer report data daily.[65] This only allows for comparison between states for the major data points of cases, deaths, tests, and vaccinations. Comparisons at a more granular level require states to use identical naming conventions and data collection procedures.[66] At this point in the pandemic, we

61. Beth Blauer, *Where's (Unvaccinated) Waldo?*, JOHNS HOPKINS CORONAVIRUS RES. CTR.: PANDEMIC DATA INITIATIVE (May 21, 2021), https://coronavirus.jhu.edu/pandemic-data-initiative/data-outlook/where-s-unvaccinated-waldo.

62. *Id*.

63. Jacqueline Houtman, Rebecca Glassman, Lindsey Shultz, Jessica Malaty Rivera, Emily Bass & Rick Bryant, *The Critical Challenge of Tracking Breakthrough Infections, and Why We Still Need Better Data Standards,* ROCKEFELLER FOUND. (Nov. 9, 2021), https://www.rockefellerfoundation.org/blog/the-critical-challenge-of-tracking-breakthrough-infections-and-why-we-still-need-better-data-standards/.

64. Blauer, *supra* note 30.

65. JOHNS HOPKINS CORONAVIRUS RES. CTR., *supra* note 59.

66. Blauer, *supra* note 30.

cannot even compare the effect of non-resident transmission due to travelers between states as some dashboards separate out resident and non-resident data, some remove all non-resident data, and others lump non-resident data in with resident data.[67] Additionally, not all states clearly explain their methodology for handling their data.

States were forced to make their own determinations when standing up COVID-19 data collection and reporting efforts in the absence of federal guidance or standards. This has resulted in a patchwork system that confuses the public and hinders public health efforts.[68] States continue to change their reporting methodologies, content, and frequencies, which makes interstate comparisons and analyses incredibly difficult. This becomes especially challenging for specific subpopulations, which may not be identified consistently within and across states. There was insufficient national guidance on data collection, leaving states to lean on their public health officials and figure out their own way forward. The public relying on data for personal decision-making suffers the most in a system that is prone to disorder, inconsistency, and inaccuracy.

IV. PANDEMIC DEMOGRAPHIC DATA

Data reporting is often optional. States are encouraged to report instances of over 120 notifiable diseases of concern to the CDC, but ultimately states do this on a voluntary basis.[69] The COVID-19 case surveillance worksheet that the CDC requests from all states for each case is five pages long, which may be a burden for states with limited resources.[70] The case data may be entered in an aggregate spreadsheet format, but this still requires states to acquire and translate line-level data for submission to the CDC.[71]

67. Beth Blauer, *Destination Unknown for Covid-19 Data from Travelers*, JOHNS HOPKINS CORONAVIRUS RES. CTR.: PANDEMIC DATA INITIATIVE (Dec. 6, 2021), https://coronavirus.jhu.edu/pandemic-data-initiative/data-outlook/destination-unknown-for-covid-19-data-from-travelers.

68. *Pandemic Data Initiative Expert Forum: Leading with Data*, JOHNS HOPKINS CORONAVIRUS RES. CTR. (July 16, 2021), https://coronavirus.jhu.edu/live/events/pandemic-data-initiative-expert-forum.

69. CTRS. DISEASE CONTROL & PREVENTION, *supra* note 47 ("States voluntarily inform CDC when a person meets certain criteria to become a case.").

70. HUMAN INFECTION WITH CORONAVIRUS DISEASE (COVID-19) SURVEILLANCE WORKSHEET, CTRS. DISEASE CONTROL & PREVENTION, https://www.cdc.gov/ncird/surveillance/downloads/COVID-19-Surveillance-Worksheet-508.pdf (last visited Dec. 6, 2021).

71. *Id.*

Regardless of implementation challenges at the state level, the CDC's COVID-19 reporting worksheet is a prime example of how detailed demographic data can and should have been collected throughout the pandemic. For every case of COVID-19, the CDC requests rich metadata on age, sex, ethnicity, race, symptomology, travel history, previous infections, vaccination status, and comorbidities.[72] If public health officials had access to such complete data for even a portion of COVID-19 cases in the United States, the pandemic would have looked very different. As it stands, each locality chooses to collect and report different quantities of metadata.[73] Data collected at the local level are then funneled up to the state health departments, which transmit data to the CDC and release a portion of the data publicly.[74]

The Johns Hopkins Coronavirus Resource Center ("CRC") endeavored to aggregate all demographic data that states have chosen to collect and report publicly for the entire United States.[75] The intention behind this project was to provide better insight on the pandemic's differing impact on certain groups, informing policymakers and health officials as they continue to craft relief strategies.[76] The CRC manually searches each state's department of health website and COVID-19 dashboard to determine if and where they publicly report

72. *Id*. at 1.

73. *See* Lynn M. Schriml, Maria Chuvochina, Niel Davies, Emiley A. Eloe-Fadrosh, Robert D. Finn, Philip Hugenholtz, Christopher I. Hunter, Bonnies L. Hurwitz, Nikos C. Kyrpides, Folker Meyer, Ilene Karsch Mizrachi, Susanna-Assunta Sansone, Granger Sutton, Scott Tighe & Ramona Walls, *COVID-19 Pandemic Reveals the Peril of Ignoring Metadata Standards*, 7 SCI. DATA 188 (2020), https://www.nature.com/articles/s41597-020-0524-5 ("Describing WHO, WHAT, HOW, WHERE, and WHEN of genomic data enables comparative analysis, informs public health responses, drives assessment of outbreak progression and reveals variation in the host-specificity, modes of transmission, and sample collection protocols. [ ] Descriptions of data are known as metadata. It is an unglamorous corner of science, but metadata standards are vital infrastructure – often holding the key for data- driven research discoveries.").

74. CTRS. DISEASE CONTROL & PREVENTION, *supra* note 47 ("CDC conducts case surveillance through the National Notifiable Diseases Surveillance System (NNDSS). In the case surveillance process, about 3,000 health departments gather and use data on disease cases to protect their local communities. Through NNDSS, CDC receives and uses these data to keep people healthy and defend America from health threats.").

75. *Disparity Explorer*, JOHNS HOPKINS CORONAVIRUS RES. CTR., https://coronavirus.jhu.edu/data/disparity-explorer (last modified Feb. 11, 2022).

76. *Id*. ("In states across the nation, COVID-19 has afflicted certain groups of people at rates that exceed their share of populations. [D]etecting disparities across all demographic categories in all states is impossible because so few health agencies collect the necessary data. [ ] This graphic depicts each subcategory within those major demographic divisions").

demographic data.[77] Sometimes these data take the form of slideshows, PDFs, and press briefings as opposed to downloadable data files, complicating the process and making the information more difficult to access for the public.[78] Once all sources are identified, the data is manually compiled into a public Github repository.[79] These data are then updated every two to four weeks.[80]

The CRC team's first takeaway was that not all states report cases, testing, deaths, and vaccination by age, sex/gender, ethnicity, and race. In fact, no single state reports all four demographic categories for all four data types.[81] As of January 2022, 42 states publicly disaggregated cases by age, 11 reported tests, 43 reported deaths, and 41 reported vaccinations.[82] Forty-six states reported case data by sex and gender, 10 reported tests, 43 reported deaths, and 38 reported vaccinations.[83] Ethnicity is often a binary selection, yet only 38 states reported case data by ethnicity, 8 reported tests, 38 reported deaths, and 37 reported vaccinations.[84] The outlook for race data is the most disappointing, with only 26 states reporting disaggregated case data, 3 reporting tests, 28 reporting deaths, and 27 reporting vaccinations.[85] The lack of a complete data set is due to some omissions from all states as opposed to a small portion of states providing little to no data. For example, in January 2022, Illinois reported case, death, testing, and vaccination data by age, sex, and ethnicity, but provided no data disaggregated by race alone.[86]

Outside of incomplete reporting, one of the most significant complications to the CRC demographic data aggregation process is a lack

77. *Ctrs. for Civic Impact: Standardization Process, https://github.com/govex/COVID-19/blob/master/data_tables/demographic_data/COVID19_demographics_standardization_process.md (last visited Dec. 7, 2021).*

78. *Id.*

79. *Standardization Process*, GITHUB: GOVEX/COVID-19, https://github.com/govex/COVID-19/blob/master/data_tables/demographic_data/COVID19_demographics_standardization_process.md (last visited Dec. 7, 2021).

80. *The Demographics of COVID*, JOHNS HOPKINS CORONAVIRUS RES. CTR., https://coronavirus.jhu.edu/data/racial-data-transparency (last updated Feb. 11, 2022).

81. *See id*. ("Many states do not provide data for several demographic categories, especially for specific ethnicities."); Beth Blauer, *Filling in the Map of COVID-19 Demographic Data*, JOHNS HOPKINS CORONAVIRUS RES. CTR.: PANDEMIC DATA INITIATIVE (Sept. 20, 2021), https://coronavirus.jhu.edu/pandemic-data-initiative/data-outlook/filling-in-the-map-of-covid-19-demographic-data ("Complete data for any single demographic in any single data category for all 50 states does not exist.").

82. *Id*.

83. *Id.*

84. *Id.*; *see infra* Part II.

85. *Id.*

86. JOHNS HOPKINS CORONAVIRUS RES. CTR., *supra* note 75.

of categorization standards across states that did provide data.[87] Even with something as simple as age, some states chose to report data in five-year increments, others in ten-year increments, and some with less logical methods.[88] This problem with age was addressed by manually rebinning all age data from states into consistent ten-year bins.[89] The rebinning process relied on a statistical assumption that within each state's chosen age group there was a uniform distribution across the ages present.[90] This solution is not ideal, but it is a necessary simplification when dealing with large quantities of dissimilar data.

The naming convention obstacles were more complex with ethnicity, race, and sex. Without any modification or consolidation, the CRC determined there were 1,098 unique categories for demographics in COVID-19 case data alone as of June 2021.[91] That figure does not include the different categories present in testing, death, and vaccination data; there are frequently differences as some states have separate arms of their health departments running data collection on vaccinations with their own standards and naming conventions.[92] This absurd quantity also ignores states that provide data on cross-correlations, such as "non-Hispanic, black women, aged 31-40."[93]

The CRC team attempted to address this data chaos with sensitivity by looking at the raw data from each state and determining which categories could be combined as they were the same classification, just using different names.[94] For example, "Caucasian" and "White" were combined into "White."[95] Any categories that were uncommon across states were combined into the "Other" category.[96] This solu-

87. Blauer, *supra* note 67.

88. Blauer, *supra* note 81.

89. *Id*.; GLENN F. KNOLL, RADIATION DETECTION AND MEASUREMENT 703 (3d ed. 2000), https://www.fulviofrisone.com/attachments/article/444/Radiation%20Detection%20and%20Measurement,%203rd%20ed%20-%20Glenn%20F.%20Knoll%20(Wiley,%202000).pdf; Joseph C. Lemaitre, Kyra H. Grantz, Joshua Kaminsky, Hannah R. Meredith, Shaun A. Truelove, Stephen A. Lauer, Lindsay T. Keegan, Sam Shah, Josh Wills, Kathryn Kaminsky, Javier Perez-Saez, Justin Lessler & Elizabeth C. Lee, *A Scenario Modeling Pipeline for COVID-19 Emergency Planning*, SCI. REP. (Apr. 6, 2021), https://www.nature.com/articles/s41598-021-86811-0.

90. Blauer, *supra* note 81; KNOLL *supra* note 89; Lemaitre et al., *supra* note 89.

91. Blauer, *supra* note 30.

92. *Id*.

93. Blauer, *supra* note 30.

94. *Id.*

95. Beth Blauer, *Detailed Demographic Data Highlights Health Disparities*, JOHNS HOPKINS CORONAVIRUS RES. CTR.: PANDEMIC DATA INITIATIVE (Nov. 29, 2021), https://coronavirus.jhu.edu/pandemic-data-initiative/data-outlook/detailed-demographic-data-highlights-health-disparities.

96. *Id.*

tion is imperfect as it ignores data on small, at-risk subpopulations like nonbinary or transgender individuals that are not acknowledged by data collection in most states.[97]

Finally, these data are subject to inordinate amounts of sampling bias. Even when states provide data disaggregated by demographic categories, the demographic metadata is often unavailable for a significant portion of data points. In some states, the demographic data provided is representative of less than 30% of total data points.[98] With limited participation, the data can easily be skewed towards areas with the funding, time, and resources to collect and report detailed demographic data.[99] Unfortunately, areas with a larger proportion of at-risk groups are often those with the least public health funding, leading to the hypothesis that minority groups are seriously undercounted in the demographic data reported.[100] Additionally, with such diversity in demographic categorization, the representation in the "Other" category can be significant, especially when "Other" includes "Unknown," "Pending," and "Declined to Answer."[101] If most of the "Other" data points were assigned to one demographic group, the results could dramatically change.[102]

COVID-19 demographic data is messy in the United States, but the CRC aims to glean some actionable information out of this aggregation. While in no way conclusive due to the complications discussed, the CRC's aggregate demographic data can be compared to census data to identify health disparities on the state level.[103] Government leaders could then utilize this knowledge of disparities to craft policy to address health inequalities and collect better, more granular demographic data in the future.

The demographic data available paints a clear picture: the COVID-19 pandemic has not affected all groups equally across the United States.[104] There have been no major scientific findings of dra-

97. Blauer & Klein, *supra* note 31.

98. *Id.* ("[S]ome data sets contain sizable "unknown" metrics which, if allocated disproportionately to certain demographic groups, could completely reverse trends observed."); Soo Rin Kim & Matthew Vann, *Many States Are Reporting Race Data for Only Some COVID-19 Cases and Deaths*, FiveThirtyEight (May 7, 2020), https://fivethirtyeight.com/features/many-states-are-reporting-race-data-for-only-some-covid-19-cases-and-deaths/.

99. *See* Blauer, *supra* note 95.

100. Johns Hopkins Coronavirus Res. Ctr., *supra* note 75.

101. Blauer, *supra* note 67.

102. Blauer, *supra* note 95.

103. *Id*.

104. Johns Hopkins Coronavirus Res. Ctr.: Disparity Explorer, *supra* note 75.

matic differences in viral transmission based on demographic differences. While females may have less severe disease than men,[105] similar proportions of men and women would still be expected to get infected. Therefore, major differences in COVID-19 cases, tests, and vaccinations could be attributed to societal structures that make certain people more vulnerable and give them less access to resources.[106]

This aggregate demographic data reveals a significant number of inequities across the United States as of December 2021. For the purposes of this investigation, a disparity is defined as a difference of greater than or equal to 5% of the census proportion for a group (e.g., 31% of Arizona is Hispanic or Latino according to the most recent census, but as of December 2021 only 11% of vaccines had gone to people who identify as such).[107] Out of the states that share data disaggregated by ethnicity, five report a disparate number of cases in the Latinx population, for those who identified as Hispanic or Latino[108] two states report disparate deaths, and five have not administered enough vaccines to the Latinx community.[109] The inequities are even more stark in the category of race due to the larger number of subpopulations. Of the 29% of states that report cases by race show a disparity of some degree, 23% have a disparity in deaths, 100% (only three states) show disparities in testing, and 88% have inequitable vaccine distribution.[110] Hawaii is an interesting case where Native Hawaiians comprise 10% of the population according to the 2020 census, but they account for 29% of cases and 37% of deaths.[111]

Disparities can then influence each other in a feedback loop that distorts the on-the-ground situation and the impact of health inequalities. For instance, if a group is underrepresented in testing data, they are likely undercounted in case data as well. Additionally, if vaccines

105. Jian-Min Jin, Peng Bai, Wei He, Fei Wu, Xiao-Fang Liu, De-Min Han, Shi Liu & Jin-Kui Yang, *Gender Differences in Patients with COVID-19: Focus on Severity and Mortality*, 8 FRONTIERS PUB. HEALTH 152 (2020), https://www.frontiersin.org/articles/10.3389/fpubh.2020.00152/full?fbclid=IWAR0j28d7CvO1w_CKJyFyyaE4PkjERGrRNZQe4TdNo_XmBSQ_H-8ZQM_pjZ4.

106. Blauer, *supra* note 95.

107. *Id*. ("[T]he CRC has only highlighted a demographic difference as a health disparity if the divergence is over 5% of what would be expected and there is not an egregious amount of "unknown" data points.").

108. *Id*.

109. JOHNS HOPKINS CORONAVIRUS RES. CTR., *supra* note 75.

110. *Id*. ("If policymakers and health professionals want to end both the COVID-19 pandemic and systemic inequalities, we need to improve how we collect and share demographic data with the public.")

111. JOHNS HOPKINS CORONAVIRUS RES. CTR., *supra* note 75.

are not distributed equitably, that can increase the case and death data on groups who have not had ample access to vaccination.[112]

While demographic disparities in the data can be disheartening, community, health, and political leaders should use these data to address the social determinants of health responsible for the disparities. They can use the data to identify the groups in greatest need or places where testing and vaccines are not adequately available.[113] However, any action requires more complete and reliable data. The current state of state demographic data is barely acceptable to inform high-level policy decisions.

V. CONSEQUENCES OF DEFICIENT DATA

Demographic data is a tool for policymakers to inform their decision-making, and low-quality demographic data can lead to ineffective policymaking and exacerbated health disparities. Most urgently, demographic data should be closely examined by policymakers as they try to understand the root causes of health disparities and devise approaches to address them. However, the presence of certain biases within COVID-19 demographic data cannot be ignored. These biases may arise due to selective sampling, reduced reporting, limited spatial

112. *Id.*; Amelia G. Johnson, Avnika B. Amin, Akilah R. Ali, Brooke Hoots, Betsy L. Cadwell, Shivani Arora, Tigran Avoundjian, Abiola O. Awofeso, Jason Barnes, Nagla S. Bayoumi, Katherine Busen, Carolyn Chang, Mike Cima, Molly Crockett, Alicia Cronquist, Sherri Davidson, Elizabeth Davis, Janelle Delgadillo, Vajeera Dorabawila, Cherie Drenzek, Leah Eisenstein, Hannah E. Fast, Ashley Gent, Julie Hand, Dina Hoefer, Corinne Holtzman, Amanda Jara, Amanda Jones, Ishrat Kamal-Ahmed, Sarah Kangas, FNU Kanishka, Ramandeep Kaur, Saadiah Khan, Justice King, Samantha Kirkendall, Anna Klioueva, Anna Kocharian, Frances Y. Kwon, Jacqueline Logan, B. Casey Lyons, Shelby Lyons, Andrea May, Donald McCormick, Erica Mendoza, Lauren Milroy, Allison O'Donnell, Melissa Pike, Sargis Pogosjans, Amy Saupe, Jessica Sell, Elizabeth Smith, Daniel M. Sosin, Emma Stanislawski, Molly K. Steele, Meagan Stephenson, Allen Stout, Kyle Strand, Buddhi P. Tilakaratne, Kathryn Turner, Hailey Vest, Sydni Warner, Caleb Wiedeman, Allison Zaldivar, Benjamin J. Silk & Heather M. Scobie, *COVID-19 Incidence and Death Rates Among Unvaccinated and Fully Vaccinated Adults with and Without Booster Doses During Periods of Delta and Omicron Variant Emergence – 25 U.S. Jurisdictions, April 4 – December 25, 2021*, MORBIDITY & MORTALITY WKLY REP. (Jan. 28, 2022), https://www.cdc.gov/mmwr/volumes/71/wr/mm7104e2.htm#:~:text=during%20October%E2%80%93November%2C%20unvaccinated%20persons,vaccinated%20persons%20without%20booster%20doses ("During October-November, unvaccinated persons had 13.9 and 53.2 times the risks for infection and COVID-19-associated death, respectively, compared with fully vaccinated persons without booster doses.").

113. Jennifer Nuzzo & Beth Blauer, *Constrained Testing Efforts Require Data on Testing Accessibility*, JOHNS HOPKINS CORONAVIRUS RES. CTR.: PANDEMIC DATA INITIATIVE (Oct. 11, 2021), https://coronavirus.jhu.edu/pandemic-data-initiative/data-outlook/constrained-testing-efforts-require-data-on-testing-accessibility; Blauer, *supra* note 61.

and temporal resolution, or inappropriate analytical methods.[114] The use of incomplete demographic data or that collected with poor or unclear methodologies may result in miscommunication, prejudice, ineffective action, and, at worst, aggravation of health disparities.[115]

Often during the COVID-19 pandemic, limited accessibility and collection of demographic data has reduced its power.[116] That includes both the lag time on updates, and that for most cases — deaths, tests, and vaccines — no demographic data are available.[117] When demographic data are only available for certain incidences, the data are inherently biased towards those who reported, which can often be more affluent areas that have the resources to collect and report high-quality demographic data.[118] This leaves a large quantity of "unknown" responses and, consequently, limits the reliability of the dataset as a whole.[119]

But even if data collection is expanded, that will not resolve the issue of bias. That is because concealing biases exposes policymakers to the risk of major missteps when trying to address the health disparities revealed by these data. And while some biases that arise during data collection may be unavoidable, their influences on policy should be limited through detailed explanation of the methodology behind data collection and analysis. Another way to minimize the impact of

114. Blauer, *supra* note 95; Blauer, *supra* note 13; Jonathan Schwabish, *Combining Racial Groups in Data Analysis Can Mask Important Differences in Communities*, URBAN WIRE (Mar. 22, 2021), https://www.urban.org/urban-wire/combining-racial-groups-data-analysis-can-mask-important-differences-communities.

115. Blauer, *supra* note 95 ("If policymakers and health professionals want to end both the COVID-19 pandemic and systemic inequalities, we need to improve how we collect and share demographic data with the public.").

116. JOHNS HOPKINS CORONAVIRUS RES. CTR., *supra* note 75. ("[D]etecting disparities across all demographic categories in all states is impossible because so few health agencies collect the necessary data.").

117. *Id*.

118. *See, e.g.*, Christine Spolar, *Data Analysts Proved What Black Pittsburgh Knew About COVID's Racial Disparities*, NPR (Dec. 7, 2021), https://www.npr.org/sections/health-shots/2021/12/07/1061099570/covid-race-disparities-exposed-by-data-analysts-and-community-leaders ("Mapping the locations of COVID-19 testing centers and analyzing that data has proved sobering. . . . People most likely to be tested lived in Pittsburgh's predominantly white neighborhoods. Largely employed in tech, academia and finance, those residents could easily adapt to lockdowns. They had round-the-clock internet at home and could afford food deliveries to limit the chance of infection. Later, when coronavirus vaccines were developed and distributed, they could get those shots more quickly, too.").

119. JOHNS HOPKINS CORONAVIRUS RES. CTR., *supra* note 75. ("[S]ome disparities that appear to qualify as significant will not be highlighted when the percentage of "unknowns" is too high to perform reliable calculations."). Importantly, "unknown" may include vulnerable groups, including individuals who are undocumented, who may be hesitant to provide any demographic data.

reporting bias is through the systematic collection of additional demographic data to make the dataset more complete.[120]

Policymakers must be made aware of shortcomings with demographic data or they risk major missteps and miscommunications when trying to address the health disparities revealed by these data. Terminology has been an important component of all pandemic communications. State and local leaders have relied on those with scientific expertise to explain technical jargon to the public.[121] This has not always gone smoothly, as the public generally does not understand how to read and interpret data without some guidance.[122] With respect to demographic data, this has produced some noteworthy examples of miscommunication, especially when discussing disproportionate impacts of COVID-19 on certain groups.[123] When the public (which generally lacks scientific or research training) hears that "a disproportionate number of COVID-19 cases have affected Black and Latinx people," they often misinterpret that statement as "Black and Latinx people are more likely to have COVID-19."[124] The context of demographic data is necessary to communicate that these

120. *See, e.g.*, Joshua E. Porterfield, *Q&A: Connecting and Collecting COVID-19 Data on Race and Social Determinants of Health*, JOHNS HOPKINS CORONAVIRUS RES. CTR.: PANDEMIC DATA INITIATIVE, https://coronavirus.jhu.edu/pandemic-data-initiative/expert-insight/q-and-a-connecting-and-collecting-covid-19-data-on-race-and-social-determinants-of-health (last visited Mar. 1, 2022) ("We have to figure out how to think about, collect, and disaggregate data on social drivers of health. In order to do that, we have to do a better job of thinking about multiracial groups, as well as many other racial and ethnic populations. Currently, we don't have that data. Everybody falls into four or five overly broad categories.").

121. *See* Katy Steinmetz, *Coronavirus: A Glossary of Terms to Help You Understand the Unfolding Crisis*, TIME (Mar. 23, 2020), https://time.com/5798684/coronavirus-glossary-definitions/ ("Two of the most widely felt symptoms of the coronavirus are uncertainty and confusion. Part of this is about jargon. A doctor can make bad news even more alarming by using scientific terms that the patient doesn't understand. And it doesn't help the masses trying to get a grasp on just what – and how bad – the situation with this virus is when discussions about it inevitably drift into technical territory.").

122. *See, e.g.*, Sara E. Brownell, Jordan V. Price & Lawrence Steinman, *Science Communication to the General Public: Why We Need to Teach Undergraduate and Graduate Students this Skill as Part of Their Formal Scientific Training*, 12 J. UNDERGRAD NEUROSCIENCE EDUC. 1, E6 (2013) ("[S]cientists need to be good communicators but communicating science to laypeople is not a trivial task. Scientific ideas can be complicated, and communication of these ideas often becomes mired in discipline-specific jargon and terminology.").

123. *See* Blauer, *supra* note 30 ("Demographics data are meant to help identify and aid all members of our society, and especially those who are vulnerable. Labels like "disproportionate," "health disparities," and "hesitancy" are common, but without complete data to support those claims, we risk using the data to spread and substantiate prejudice and distrust, as explained by Dr. Alexandre White.").

124. Joshua E. Porterfield, *Q&A: Public Health Lessons from Historic (and Current) Pandemic Data*, JOHNS HOPKINS CORONAVIRUS RES. CTR. (Sept. 16, 2021), https://coronavirus.jhu.edu/pandemic-data-initiative/expert-insight/q-and-a-public-health-lessons-from-historic-and-current-pandemic-data.

discrepancies are indicative of health disparities as opposed to the assumed inaction or lack of responsible action from certain demographic groups.[125]

Even when subject matter experts are able to communicate effectively with the public, some terms get mutated and misused, such as "super spreader" and "vaccine hesitant," which have become part of the vernacular throughout this pandemic.[126] Incorrectly analyzed demographic data can result in the inappropriate association of certain groups and individuals with these labels. In addition to being prejudiced and unfounded, the attachment of these labels to certain demographic groups can be damaging.[127] If a group is constantly told that they are "vaccine hesitant" when, in reality, they do not have adequate access and support to get vaccinated, they may adopt that moniker and psychologically accept that maybe they are indeed vaccine hesitant.[128] This also can fuel racism and xenophobia as certain groups are demonized as super spreaders and vaccine hesitant,[129] thus highlighting the need for demographic data to be thoroughly communicated to the public in order to minimize bias.[130]

When deficient demographic data is then used as the basis for policy, resource allocation, and relief effort design, the resulting actions can be ineffective or further detrimental. Political leaders often discuss the merits of using detailed vaccination data to identify those who are unvaccinated in order to increase access or tailor advertising.[131] This idea, while admirable, is impossible to enact effectively without complete, detailed demographic data. Unless the data truly reveal who is vaccinated — and who is not — mobile vaccine units,

125. *See id*. ("When we look back at COVID-19 data, it will be very important to disentangle and analyze these data within a wider historical, social, political context that disabuses us of easy conclusions that suggest inherent inferiority of certain groups due to race, class, gender, sexuality, or a host of other factors that have been used to oppress people within society.").

126. Tim Herrera, *The 20 Phrases that Defined 2020*, N.Y. TIMES (Dec. 21, 2020), https://www.nytimes.com/2020/12/18/style/words-of-the-year-2020.html.

127. Porterfield, *supra* note 120.

128. *Id.*

129. Ed Yong, *America Is Getting Unvaccinated People All Wrong*, THE ATLANTIC (July 22, 2021), https://www.theatlantic.com/health/archive/2021/07/unvaccinated-different-anti-vax/619523/; *COVID-19 Fueling Anti-Asian Racism and Xenophobia Worldwide*, HUM. RTS. WATCH, (May 12, 2020), https://www.hrw.org/news/2020/05/12/covid-19-fueling-anti-asian-racism-and-xenophobia-worldwide.

130. *See* Porterfield, *supra* note 120 ("We talk about data in the same way we talk about vaccine hesitancy – in a broad way that means many different things. We have to think about integrity, quality, usage, application, and disaggregation of data by racial and ethnic groups and by social drivers.").

131. Johns Hopkins Coronavirus Res. Ctr., *Pandemic Data Initiative Expert Forum: Leading with Data*, YOUTUBE (Sept. 17, 2021), https://www.youtube.com/watch?v=3_97VZ_9KkY.

additional doses, and advertising campaigns can go to waste.[132] This may also increase the severity of health disparities as areas with less need receive additional unnecessary resources, and groups with the greatest need are further ignored.

Without complete, reliable, and rigorously analyzed demographic data, political leadership cannot hope to make significant headway in combating health disparities. Even data-minded policymakers who are committed to evidence-informed policy are limited by the data available to them. While this observation does not minimize the potential power of demographic data, it highlights that the quality of available COVID-19 demographic data is insufficient and prone to bias.

VI. BETTER DEMOGRAPHIC DATA FOR A BETTER TOMORROW

Many in the public health data community assert that the federal government should simply mandate that sub-national health departments report all demographic data to the CDC using the standard forms provided. This "simple" solution comes with many stumbling blocks. Due to the limited powers of the Executive Branch, neither the CDC, nor the President likely have the power to require this.[133] As was seen with hospitalization data, successful mandates were tied to funding requirements from the CMS for enforcement within hospitals, indicating that the Legislative Branch could enforce data collection through its spending powers.[134] Even if there was federal power for mandated demographic data, our medical infrastructure is not prepared to handle increased demand for robust demographic data.

The funding attached to data reporting mandates could inherently include financial resources needed to modernize and hire addi-

132. Blauer, *supra* note 61.

133. *See National COVID-19 Case Surveillance*, U.S. CTRS. DISEASE CONTROL & PREVENTION (last modified July 23, 2021), https://www.cdc.gov/coronavirus/2019-ncov/covid-data/faq-surveillance.html ("Public health departments routinely collect information on people with certain infections. This process, known as case surveillance, can help officials understand where, when, and in which populations an illness is transmitted. This supports action to control outbreaks and prevent the spread of disease. . . . State, local, and territorial health departments transmit case data to CDC through the National Notifiable Diseases Surveillance System. This process is voluntary.").

134. AM. HOSPITAL ASS'N, *supra* note 49 ("The Centers for Medicare & Medicaid Services late today released guidance on how it will implement its August interim final rule that makes collecting and reporting COVID-19 data a condition of participation for hospitals that participate in Medicare. The guidance includes new reporting requirements for hospitals, as well as enforcement provisions.").

tional personnel to comply; however, the cost of nationwide data modernization will be difficult to estimate. The CDC has already spent over $1 billion on data modernization, with the majority of that funding committed to updates at the CDC and not at the state and local levels.[135] There will have to be significant funding allocated for trained, committed personnel at all levels of health systems to enable effective data collection and reporting. For example, long-term care facility workers are already overextended and cannot be expected to upload data to three different systems (long-term care facility organization, sub-national health department, and CDC) when there may not even be anyone in charge of data transmission.[136] That issue is not uncommon, and will require funding mechanisms with resilience and foresight to effectively build modern health data infrastructure. Whether or not mandates are proposed to solve our demographic data discrepancies, infrastructure modernization is a necessity.

The best solutions to the demographic data crisis will couple major policy and funding changes with modernization of the local, state, and CDC data reporting systems, especially the NNDSS. One option may be developing a new national data submission system that allows healthcare providers to directly upload data simultaneously to the CDC and the relevant sub-national health department, removing the need for two different formats of data entry for similar uses.[137] A diverse array of expert voices will be essential to redesigning current data systems as any workable solution most likely rests at the intersection of data science, social science, computer science, epidemiology, engineering, and medicine.

Even if CDC demographic data reporting systems are modernized, the demographic categories that define the data feeding into

135. Beth Blauer, *Data Modernization: Improving Data to Improve Health*, JOHNS HOPKINS CORONAVIRUS RES. CTR.: PANDEMIC DATA INITIATIVE (Feb. 14, 2022), https://coronavirus.jhu.edu/pandemic-data-initiative/data-outlook/data-modernization-improving-data-to-improve-health.

136. *See, e.g.*, Joshua E. Porterfield, *Q&A: Universal Testing Data Provides Community Insight*, JOHNS HOPKINS CORONAVIRUS RES. CTR.: PANDEMIC DATA INITIATIVE (Sept. 1, 2021), https://coronavirus.jhu.edu/pandemic-data-initiative/expert-insight/q-and-a-universal-testing-data-provides-community-insight ("A lot of these facilities don't have unified electronic health records. Many of them are still working with paper records. Data reporting often relies on one individual going through their list of the residents and staff that are infected, and physically typing in the data on a daily or weekly basis. Then they have to enter the data into various databases, sometimes multiple databases on a state or federal level.").

137. Porterfield, *supra* note 136 ("There's certainly a high potential for human error [when the same data must be entered in different formats.]").

these systems require significant updates as well.[138] The race and ethnicity categories set by the Office of Management and Budget in 1997 are not sufficient for disaggregating data from the diverse people who reside in this country.[139] In addition to missing race and ethnicity definitions (e.g., Middle Eastern), the current multi-racial categorizations are also insufficient.[140] "Two or more races" is not a useful categorization when someone who is "White" and "Asian" will experience the social determinants of health differently than someone who is "Black or African American" and "White."[141] The same categorization issues arise for sex and gender, which have no requirements set by the Office of Management and Budget.[142] Transgender, nonbinary, and intersex individuals deserve accurate representation in demographic data and have significantly different health needs that merit separate data collection.[143]

Fundamentally, many issues with demographic categorization stem from insufficient representation in relevant conversations. Put simply, the root of the issue is inclusive governance. When attempting to determine demographic categories, the opinions shared should come from all groups of people, even before the policy changes reach the point of public input. Recategorizing sex cannot be done without LGBTQIA+ representation just as recategorizing ethnicity cannot happen without members of the many different sections of the Latinx

138. Beth Blauer, *Data Disarray Damages COVID-19 Response, Experts Say*, HUB (June 17, 2021), https://hub.jhu.edu/2021/06/17/beth-blauer-data-disarray-in-covid-reporting/. ("There are no standards for categorizing demographic data, so individual decisions to label categories with similar but different names, such as "Hawaiian" vs. "Hawaiian/Pacific Islander," complicate the data. There are currently 1,098 different demographic categories reported by the U.S. states and territories, which is an unmanageable quantity. This description of data disarray does not even include testing, hospitalization, or cross-categorization metrics, such as "white women aged 30-45," which would add thousands more categories.").

139. FED. REG., *supra* note 25.

140. Blauer, *supra* note 29.

141. *See, e.g.*, Porterfield, *supra* note 120 ("Our minimal national standards for racial and ethnic categorization, which are set by the U.S. Office of Management and Budget, leave out a wide range of people because the government hasn't kept up with changing demographics.").

142. *See* Joshua E. Porterfield, *Q&A: Let's Talk About Sex, Gender, and Intersectionality*, JOHNS HOPKINS CORONAVIRUS RES. CTR.: PANDEMIC DATA INITIATIVE (Aug. 19, 2021), https://coronavirus.jhu.edu/pandemic-data-initiative/expert-insight/lets-talk-about-sex-gender-and-intersectionality ("The published literature is not thinking of sexual minorities in the context of biological responses or outcomes from infection or vaccination. . . . If we don't have accurate data on the intricacies of a patient's biological sex, then they may not receive the right medical information.").

143. *Patient-Centered Care for Transgender People: Recommended Practices for Health Care Settings*, CTRS. DISEASE CONTROL & PREVENTION, https://www.cdc.gov/hiv/clinicians/transforming-health/health-care-providers/affirmative-care.html#understanding (last modified Apr. 1, 2020).

community. We need to start by asking how people identify themselves and how the health needs of their communities can be better served by improved demographic information, considering many people do not believe current census categories accurately reflect their identities.[144]

Detailed demographic data has already been shown to be a powerful tool in smaller communities across the United States throughout the COVID-19 pandemic.[145] In Baltimore, Maryland, for example, the City Health Department established its own COVID-19 dashboard with more detailed demographic data reporting than the Maryland state dashboard.[146] Rather than simply report total cases, deaths, and tests, Baltimore provides each of those data points disaggregated by age, ethnicity, race, and sex according to census categorizations.[147] Additionally, this dashboard allows for intersectional exploration.[148]

As of December 3, 2021, Baltimore reported 64,862 cases of COVID-19.[149] Its data reveals that 39,143 of those were Black.[150] Out of those 39,143 cases, 22,219 (57%) were female, 4,143 of whom were aged 20–29.[151] This level of detail has empowered the City Health Department to identify and reach out to communities that are suffering more than expected to improve communication and assistance.[152] This targeted, effective action is only possible due to detailed demographic data.

Unfortunately, Baltimore is a unique example. Most cities and many states do not collect or report sufficient demographic data for

144. Cohn et al., *supra* note 28.

145. *See* Samantha Artiga, Kendal Orgera, Olivia Pham & Bradley Corallo, *Growing Data Underscore that Communities of Color Are Being Harder Hit by COVID-19*, KFF (Apr. 21, 2020), https://www.kff.org/policy-watch/growing-data-underscore-communities-color-harder-hit-covid-19/ ("Similar to earlier state data, they suggest that the virus is having disproportionate effects, with Black people accounting for 34% of confirmed cases with known race/ethnicity compared to 13% of the total population as of April 20, 2020.").

146. *Coronavirus 2019 Disease, Baltimore City COVID-19 Dashboard*, CITY OF BALTIMORE, https://coronavirus.baltimorecity.gov/ (last visited Dec. 21, 2021).

147. *Id*.

148. *Id*.

149. *Id.*

150. Joshua E. Porterfield, *Q&A: COVID-19 Fiscal Stimulus Policies Can Benefit Climate and Economies*, JOHNS HOPKINS CORONAVIRUS RES. CTR.: PANDEMIC DATA INITIATIVE (Dec. 1, 2021), https://coronavirus.jhu.edu/pandemic-data-initiative/expert-insight/q-and-a-covid-19-fiscal-stimulus-policies-can-benefit-climate-and-economies.

151. Joshua E. Porterfield, *Q&A: Hunger for Data to Track Global Food Insecurity*, JOHNS HOPKINS CORONAVIRUS RES. CTR.: PANDEMIC DATA INITIATIVE (Sept. 22, 2021), https://coronavirus.jhu.edu/pandemic-data-initiative/expert-insight/q-and-a-hunger-for-data-to-track-global-food-insecurity.

152. JOHNS HOPKINS CORONAVIRUS RSCH. CTR., *supra* note 68.

data-driven action to address the social determinants of health.[153] Rampant health disparities existed well before the COVID-19 pandemic,[154] but the pressures of the pandemic have highlighted the major deficiencies of our data systems. We need better demographic data to address health disparities even in a post-pandemic world.

COVID-19 will not be the last pandemic in most of our lifetimes.[155] The pressures of climate change,[156] environmental destruction,[157] and an interconnected global economy all but ensure we will experience another pandemic. We need to prepare. By the end of 2021, there were over 53.2 million cases and 820,000 deaths due to COVID-19 in the United States.[158] In just two years, that exceeds the total number of American deaths in World War I, World War II, the Korean War, the Vietnam War, the Gulf War, the War in Afghanistan, and the Iraq War combined.[159] Detailed demographic data could have helped avoid many of those deaths, and we must be prepared to deploy it in future crises.[160]

VII. CONCLUSION

Demographic data could be a powerful tool to combat health crises, but as of now it is underdeveloped, underfunded, and underutilized. The COVID-19 pandemic has made it clear that the current,

153. *E.g.*, Rachel Lance, *As U.S. COVID-19 Deaths Top the Civil War's Toll, We're Repeating Disease History*, TIME (Aug. 14, 2021), https://time.com/6089052/covid-deaths-civil-war/.

154. *Racial and Ethnic Health Disparities – Before and During the Pandemic,* U.S. GOV'T ACCOUNTABILITY OFF. (Sept. 28, 2021), https://www.gao.gov/blog/racial-and-ethnic-health-disparities-and-during-pandemic.

155. Michael Penn, *Statistics Say Large Pandemics Are More Likely than We Thought*, DUKE GLOB. HEALTH INST. (Aug. 23, 2021), https://globalhealth.duke.edu/news/statistics-say-large-pandemics-are-more-likely-we-thought ("It found the probability of a pandemic with similar impact to COVID-19 is about 2% in any year, meaning that someone born in the year 2000 would have about a 38% chance of experiencing one by now. And that probability is only growing, which the authors say highlights the need to adjust perceptions of pandemic risks and expectations for preparedness.").

156. Porterfield, *supra* note 150.

157. Porterfield, *supra* note 151.

158. *Global and U.S. Maps*, JOHNS HOPKINS CORONAVIRUS RES. CTR., (last visited Dec. 21, 2021), https://coronavirus.jhu.edu/data; Beth Blauer, *2021: Pandemic Data Year in Review*, JOHNS HOPKINS CORONAVIRUS RES. CTR.: PANDEMIC DATA INITIATIVE (Jan. 10, 2022), https://coronavirus.jhu.edu/pandemic-data-initiative/data-outlook/2021-pandemic-data-year-in-review.

159. *See* Lance, *supra* note 153.

160. Critically, demographic data have additional uses, such as providing information about chronic disease distribution within the population and related health disparities. Lisa LeRoy, Melanie Wasserman, Michael Rezaee & Alan White, *Understanding Disparities in Persons with Multiple Chronic Conditions: Research Approaches and Data Sets*, OFF. OF THE ASSISTANT SEC'Y FOR PLANNING AND EVALUATION (Sept. 29, 2013), https://aspe.hhs.gov/reports/understanding-disparities-persons-multiple-chronic-conditions-research-approaches-datasets-0.

federated manner in which states determine their own rules for collecting and reporting on demographics is far from ideal. Major policy changes and legislation would be necessary to redesign and mend this broken system and promote demographic data accessibility and transparency. In addition to policy changes, infrastructure and personnel investments will be critical to support the accurate collection and analysis of demographic data in sub-national health departments. Demographic data can help governments address health disparities, but the data must be complete, reliable, and available in near real time. Our society cannot afford inaction to improve demographic data – this pandemic is not the last.

Policy Proceeds Law: A Global Analysis of Mental Health as a Human Right

MARA HOWARD-WILLIAMS*

Although the World Health Organization ("WHO") estimated in 2010 that the global cost of mental health was $2.5 trillion, law has historically under-addressed mental health, despite its critical role as a structural determinant of health. Since the 1960s, multiple international treaties have recognized mental health as a human right, yet 25% of states around the world have no mental health regulation. The international community has placed a renewed importance on mental health, however, law and policy still lag the evolving understanding of mental health and how best to address it.

The WHO took an important step towards encouraging a renewed emphasis on law and policy to address mental health when it created its 2013-2020 Mental Health Action Plan, which marks the first instance in which the WHO formalized an initiative to encourage countries to address mental health as a human right.

This article uses novel methods to analyze the impact of law and policy globally on mental health indicators, combining treaty data with country self-report of law and policy in the years 2013 and 2017 to assess progress towards the WHO's Plan. These empirical methods reveal that policy change is an important indicator of and precursor to changing the law to better adhere to mental health as a human right.

* JD, MPH, Public Health Analyst, Centers for Disease Control and Prevention. I am grateful for the incredible mentorship and feedback from Holning Lau at the University of North Carolina School of Law, where this work began, and colleagues in the Public Health Law Program at CDC for their dedication to developing and advancing the field of legal epidemiology. The views expressed in this article are my views only and do not represent the views of the government.

I. INTRODUCTION

Abed Itani, a toddler, refuses to wear his red shoes.[1] But unlike most toddlers, his defiance is not due to his newly learned use of the word "no." More likely, the red shoes remind him of the blood-soaked patients and the stained floor of the hospital where he was taken after the explosion in Beirut that killed 170 people and injured over 6,000.[2] The relationship between the memory and his refusal to wear red is evidenced by his repeated requests that his mother wash the shoes.[3] His mother explains how his personality has changed after the trauma: "He was a happy boy, very sociable. Now, he doesn't talk to anyone."[4]

His mother was at work at the time of the blast, out of the immediate zone of danger.[5] She struggles with guilt, feeling that her child has now experienced an all-too-familiar trauma.[6] For her and many others of her generation, the explosion brought up childhood memories of the twenty-five-year civil war in Lebanon.[7] For some, the blast was the breaking point following a series of events that negatively impacted mental health.

In 2010, the World Health Organization ("WHO") and World Bank estimated the global cost of mental health was $2.5 trillion, and estimated an increase by 2030 of 240 percent, costing $6 trillion.[8] For such a widespread problem with myriad causes affecting individuals in every country, mental health has historically been underfunded and unprioritized, "tak[ing] a back seat" to the more visible illnesses such as those caused by infectious disease.[9] It suffers from two challenges: it is "often [an] invisible and overlooked health and social burden," and it is "driven into the shadows by stigma, prejudice, and fear."[10]

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1. Dalal Mawad, *Children in Beirut Suffer from Trauma After Deadly Blast*, Associated Press (Aug. 12, 2020), https://apnews.com/article/ap-top-news-health-middle-east-lebanon-trauma-dc6fbeaa4d3181b72e9dcc8071958314.
2. *Id.*
3. *Id.*
4. *Id.*
5. *Id.*
6. *Id.*
7. *Id.*; Sarah el Deeb, *After Multiple Crises, this Time Lebanese Feel Broken*, Associated Press (Aug. 12, 2020), https://apnews.com/article/beirut-ap-top-news-international-news-middle-east-lebanon-47daece74630e5d985499722455e86c7.
8. Praticio B. Marquez & Shekhar Saxena, *Making Mental Health a Global Priority*, 2016 Cerebrum 10 (2016).
9. *Treating the Trauma of Young Syrian Refugees*, N.Y. Times (Oct. 12, 2015), https://www.nytimes.com/2015/10/13/health/treating-the-trauma-of-young-syrian-refugees.html?searchResultPosition=4.
10. Marquez & Saxena, *supra* note 8.

Similary, mental health is under-addressed in the law. While mental health concerns are widespread, mental health lacks global regulation. As of 2001, 25% of states around the world had no mental health regulation.[11] Additionally, 15% of states passed their mental health regulation before 1960, a time "before most of the currently used treatment modalities became available."[12] "[I]n most parts of the world, mental health and mental disorders are not regarded with anything like the same importance as physical health. Instead, they have been largely ignored or neglected."[13] As a result, the disease burden[14] has continued to escalate, and until relatively recently has not been an international focus.[15]

Since the turn of the century, the international community has placed more emphasis on mental health. Through publications at the WHO and increasing global awareness of the incredible disease burden mental health presents, new initiatives attempt to address mental health, and particularly mental health as a human right.

One such instrument is the WHO's 2013-2020 Mental Health Action Plan ("Plan").[16] The Plan marks the first instance in which the WHO formalized an initiative to encourage countries to address mental health as a human right.[17] Now that the timeframe for the Plan has ended, the important next step is to evaluate the Plan's potential effect on the global disease burden of mental health.

11. WHO, MENTAL HEALTH LEGISLATION & HUMAN RIGHTS 2 (2003), https://www.who.int/mental_health/policy/services/7_legislation%20HR_WEB_07.pdf.

12. *Id*.

13. THE WORLD HEALTH REPORT 2001, MENTAL HEALTH: NEW UNDERSTANDING, NEW HOPE 3 (2001)

14. Disease burden is a commonly used term in public health. In essence, disease burden is the impact that a particular disease or condition has in a designated area. While the term "disease" is part of the term, the meaning is broader than what might commonly be thought of as diseases and instead refers to any health problem. In the case of mental health, disease burden can be as narrow as the amount of people in one city that have depression, or as broad as the combined number of people throughout the globe that suffer from any mental condition that affects mental health and the social, economic, and other impact that health condition has globally.

15. *Id.*

16. S*ee generally* WHO, MENTAL HEALTH ACTION PLAN: 2013-2020 (2013), https://www.who.int/mental_health/action_plan_2013/bw_version.pdf?ua=1.

17. Shekhar Saxena, Michelle Funk & Dan Chisholm, *WHO's Mental Health Action Plan 2013-2020: What Can Psychiatrists Do to Facilitate Its Implementation?*, 13 WORLD PSYCHIATRY 107 (2014).

This article uses legal epidemiology to take a novel approach to assess global mental health law. It uses legal epidemiologic[18] methods to assess the Plan's impact on mental health by combining health data from the WHO, coded and compiled treaty data, and countrys' self-reports in response to the Plan.[19] The new field of legal epidemiology compares variations in law such as housing law, laws that impact stroke outcomes, tobacco control law, and welfare law with variations in related health outcomes, including tobacco use, eviction data, and chronic disease monitoring.[20] Those comparisons can provide valuable insight as to which types of laws impact health outcomes, and under what conditions.[21] There are no published studies that evaluate the WHO's Plan, and in particular, no study that uses legal epidemiology to assess the Plan's impact. Accordingly, this article fills a gap in the literature.

The findings of this study indicate that some countries are reporting improvements in how well mental health law and policy[22] adhere to human rights. Positive changes in policy are associated with improved mental health outcomes, which may indicate that countries reporting changes in policy are prioritizing mental health and are building the necessary infrastructure to improve mental health outcomes and use law as a tool to impact mental health.

Section I of this paper describes mental health, the right to mental health, and introduces important cultural considerations necessary to understand the global context of mental health. Section II provides a brief overview of the international instruments and WHO's formal statements which addressed mental health up until the creation of the WHO 2013-2020 Action Plan. Section III describes the WHO 2013-2020 Action Plan in detail and the mechanisms used by the WHO to analyze the plan's success. Section IV explains the legal epi-

18. Legal epidemiology is the systematic study of law as variable in the prevention, cause, and distribution of disease. Tara Ramanathan, Rachel Hulkower, Joseph Holbrook & Matthew Penn, *Legal Epidemiology: The Science of Law*, 45 J.L. MED. ETHICS 69 (2017).

19. The variables studied include suicide rates, disability adjusted life-years, ratios of mental health workers and severe cases treated per 100,000 population, self-report of law and policy adherence to human rights, and treaty signatory status. These variables are discussed in detail in Sections III(b) (treaties) and V(a) (health variables).

20. The Journal of Public Health Management and Practice issued a special supplementary issue specifically on legal epidemiology that both explains the methods and provides numerous studies that use legal epidemiology. *See generally* 26 J. PUB. HEALTH MGMT. & PRAC. S1 (2020).

21. *Id.*

22. As used in this paper, law and policy are distinct variables. Policy refers to an official governmental prioritization of mental health, whereas law refers only to that state's formally adopted laws. This is discussed in detail in Section IV.

demiologic analysis conducted including the variables selected and sources used. Section V analyzes the data in six groups, comparing the roles of law and policy change, and how these changes relate to mental health, ultimately finding that the data support a finding that policy change is a necessary predicate to both legal change and improving mental health. Section VI concludes with recommendations for future action to address the global disease burden of mental health.

II. UNDERSTANDING MENTAL HEALTH

Before proceeding with an analysis of mental health as a human right, it is important to understand what mental health is and is not, and how variations in cultures may impact assessments of mental health status and treatment, as well as the science behind related evaluations.

A. Mental Health, Social Pressures, and Stigma

This section contextualizes the explosion in Lebanon to explain how social, cultural, and historical events coalesce to impact mental health. These narratives represent themes that recur throughout this article.

Mental health concerns do not arise solely out of a single traumatic event, though they may be more recognized in such instances. Some who did not directly experience the event may still develop symptoms of mental health conditions,[23] and others may experience re-traumatization with the event triggering reminders of past traumas. For instance, Mona Zahran, described that the blast "transported her back to her childhood,"[24] when their neighborhood was bombed during the civil war—a trauma experienced by large portions of the Lebanese population—and stigma about mental health has prevented many from seeking care.[25]

23. For instance, after the explosion in Beirut, even those who were not physically injured reported symptoms of anxiety and depression at alarmingly high rates, and the inundation of stories about the event in the media may have impacted some who were not directly affected by the blast. Dalal Mawad, *Survivors of Beirut's Explosion Endure Psychological Scars*, ASSOCIATED PRESS (Feb. 1, 2021), https://apnews.com/article/mental-health-health-lebanon-coronavirus-pandemic-trauma-841742a6936e7118dd24e5c73e9831a9.

24. el Deeb, *supra* note 7.

25. Raya Jalabi & Michael Georgy, *Nightmares, Flashbacks, Fatigue: Beirut Faces Mental Health Crisis After Blast*, REUTERS, (Aug. 24, 2020, 4:10 AM), https://www.reuters.com/article/us-lebanon-security-blast-mentalhealth/nightmares-flashbacks-fatigue-beirut-faces-mental-health-crisis-after-blast-idUSKBN25K0T7.

Traditionally, many Lebanese would find mental health support outside of the clinical setting, relying on friends and family, but the explosion combined with the Covid-19 pandemic has rendered those traditional support-systems unavailable.[26] The explosion has exposed a gap in Lebanon's mental health infrastructure—a gap it is now working to fill with the help of Doctors Without Borders.[27] One woman severely injured in the blast says treatment has been helping, but that she isn't the same person anymore. She recounted, "I lost my mental health, and so I lost everything."[28]

Compounding the difficulty of obtaining already scarce resources is the scarcity of mental health practitioners. Many are leaving the country in the wake of the economic crisis made more difficult by the destruction of Lebanon's main economic center.[29] Those that stayed were individually impacted by the same event that has spurred the unprecedented demand for mental health services.[30] Outside support from NGOs provided some immediate relief, but it may take years for the community to recover from its "collective trauma."[31]

But practitioners and patients understand that mental health treatment alone is insufficient to address their needs. Abdel Salam Aref Ibrahim, a father and Syrian refugee, worked in a bakery that was destroyed in the explosion. He pointed to his immediate need for emergency cash assistance.[32] No mental health treatment can alleviate the anxiety imposed by financial insecurity, particularly when supporting a family. Some practitioners note that "[p]eople are struggling with poverty, how to make ends meet and so they don't see mental health as a priority;"[33] while alleviating poverty is a logical priority

26. *Lebanon: Mental Health Needs Support Post-Beirut Explosion*, MÉDECINS SANS FRONTIERS (last updated Apr. 15, 2021), https://www.doctorswithoutborders.ca/article/lebanon-mental-health-needs-support-post-beirut-explosion.

27. *Id.*

28. Mawad, *supra* note 23.

29. *Id.*

30. Dario Sabaghi, *Invisible Wounds: Beirut Witnesses Mental-Health Crisis After Blast*, MIDDLE EAST EYE (Sept. 27, 2020), https://www.middleeasteye.net/news/lebanon-beirut-explosion-mental-health-trauma-ptsd-crisis.

31. *Id.*

32. *After the Beirut Blasts, Lebanon Urgently Needs Medical and Mental Health Care*, UN WOMEN (Oct. 5, 2020), https://www.unwomen.org/en/news/stories/2020/10/feature-after-beirut-blasts-lebanon-needs-medical-and-mental-health-care.

33. Mawad, *supra* note 23.

over seeking mental health care, mental health status is nonetheless affected by poverty and economic insecurity.[34]

Abdel's mental health is impacted not only by the events in Lebanon, but also by the violence in Syria. Many studies have documented the severe impact of the Syrian war on mental health, particularly on children's mental health, highlighting the lifelong consequence of exposure to horrific conditions and violence.[35] The United Nations High Commissioner for Refugees ("UNHCR") published a report in 2015 specifically to detail the mental health needs and supports for working with Syrians impacted by the conflict.[36]

Displacement and injury due to armed conflict are not the only mental health stressors; the conflict has destroyed much of the infrastructure which existed prior to the war—hospitals that once provided critical care for those requiring inpatient care have vanished.[37] Families of those who require chronic treatment for severe mental health conditions such as schizophrenia have nowhere to turn, facing pharmaceutical prices that are unaffordable on the off chance that they're even attainable, and limitations on much-needed inpatient hospital

34. WHO, MENTAL HEALTH, POVERTY & DEV.: BREAKING THE VICIOUS CYCLE BETWEEN MENTAL ILL-HEALTH AND POVERTY, 2 (2007), https://www.who.int/mental_health/policy/development/1_Breakingvicioucycle_Infosheet.pdf.

35. *See, e.g.*, Ahmad Hassan, *The Syrian Mental Health Crisis: Present Findings and Future Directions*, 21 HARV. PUB. HEALTH REV. (2019) (documenting the prevalence of mental health conditions resulting from the war and highlighting the incidence of PTSD); Ekaterini Georgiadou, Ali Zbidat, Gregor M. Schmitt & Yesim Erim, *Prevalence of Mental Distress Among Syrian Refugees with Residence Permission in Germany: A Registry-Based Study*, 9 FRONT. PSYCH. 393 (2018) (researching rates of PTSD, generalized anxiety disorder, and depression among Syrian refugees residing in Germany); CDC, MENTAL HEALTH: SYRIAN REFUGEE HEALTH PROFILE (2017), https://www.cdc.gov/immigrantrefugeehealth/profiles/syrian/health-information/mental-health/index.html; Nadim Almoshmosh, *Highlighting the Mental Health Needs of Syrian Refugees*, 13 INTERVENTION 178 (2015) (reflecting on the change in mental health needs throughout the Syrian conflict); Michael Colborne, *Syrian Refugees' Mental Health is Top Priority*, 187 CMAJ 1347 (2015) (describing the trauma-informed approach to working with refugees); ZEINAB HIJAZI & INKA WEISSBECKER, SYRIA CRISIS: ADDRESSING REGIONAL MENTAL HEALTH NEEDS AND GAPS IN THE CONTEXT OF THE SYRIA CRISIS (documenting mental health case incidence, prevalence, and gaps in treatment availability), https://internationalmedicalcorps.org/wp-content/uploads/2017/07/Syria-Crisis-Addressing-Mental-Health.pdf.

36. G. HASSAN, LJ KIRMAYER, A. BERRADA, C. QUOSH, R. EL CHAMMAY, J.B. DEVILLE-STOETZEL, A. YOUSSEF, H. JEFEE-BAHLOUL, A. BARKEEL-OTEO, A. COUTTS, S. SONG & P. VENTEVOGEL, CULTURE, CONTEXT AND THE MENTAL HEALTH AND PSYCHOSOCIAL WELLBEING OF SYRIANS: A REVIEW FOR MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT STAFF WORKING WITH SYRIANS AFFECTED BY ARMED CONFLICT, UNHCR (2015), https://www.unhcr.org/en-us/protection/health/55f6b90f9/culture-context-mental-health-psychosocial-wellbeing-syrians-review-mental.html.

37. *Mental Health in Syria: Another Casualty of War*, WHO (Sept. 22, 2013), http://www.emro.who.int/syr/syria-news/mental-health-care-in-syria-another-casualty-of-war.html.

stays.[38] While NGOs are working to build in-country capacity, long-term plans do not provide the much-needed immediate relief.

Mental health is not a concern only in the Middle East, though the region does provide clear and modern examples of how life events—past and present, anticipated or shocking—can impact mental health. Other similar examples can be found throughout the globe; though not a comprehensive list, the Centers for Disease Control and Prevention compiles reports on refugee mental health status for Buhtan, Burma, Central America, Congo, Iraq, and Somalia.[39] Poverty, experienced by individuals in every country, is in and of itself a mental health stressor.[40]

B. Health Versus Healthcare

Consider a patient who schedules a doctor's visit because he has been abnormally tired lately, and is experiencing chronic pain and gastrointestinal distressed. The doctor asks the patient some questions, including if his home life is okay, and the patient explains he lost his job recently, but is otherwise okay. The doctor runs a battery of blood tests, but all the results are in the normal range. The doctor tells the patient he is clinically healthy and sends the patient home. In reality, the patient is not healthy; though the doctor found nothing clinically wrong, the patient is experiencing life-disrupting symptoms. The cause may be depression, in which an estimated nearly 70% of patients report somatic symptoms exclusively.[41]

While often thought of as separate disciplines, "talking about health without mental health is a little like tuning an instrument and leaving a few discordant notes."[42] Health and healthcare are distinct concepts; health includes but goes beyond healthcare.[43] The former is a state of being, while the latter is a provision of services generally designed to attain a health status.

38. *Id.*

39. CDC, Refugee Health Profiles (2017), https://www.cdc.gov/immigrantrefugeehealth/profiles/index.html.

40. WHO, *supra* note 34.

41. Madhukar H. Trivedi, *The Link Between Depression and Physical Symptoms*, 6 Primary Care Companion J. Clinical Psy. 12 (2004).

42. The World Health Report 2001, *supra* note 13, at ix.

43. WHO, The Right to Health, Fact Sheet 31 at 1.

Health and illness or disease are not antonyms. Health is a construct which expands beyond the absence of disease.[44] Mental health, likewise, expands beyond the absence of mental illness. The WHO defines mental health as "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community."[45] Setting aside reasonable criticisms of this definition,[46] the definition notably does not reference a complete absence of mental illness.

By contrast, healthcare directly addresses the treatment of diseases and other health conditions; mental healthcare addresses the treatment of mental illness rather than the WHO defined "state of well-being."[47] Though healthcare may be an important mechanism by which individuals attain health and mental health, the concepts are distinct; healthcare is a tool by which to achieve health—whether mental or otherwise.

C. The Role of Culture in Health

While a collection of international data on mental health, such as that created and executed by the WHO periodically,[48] is laudable and important in understanding global health, the present tools by which mental health is evaluated reflect a Western bias. Therefore, bear in mind throughout this paper that, although the presentation and amenability to treatment varies culturally throughout the globe, the best data available has a distinctly Western bias. Not all measures included in this paper are applicable to all cultures—for instance, the number of inpatient hospital beds for psychiatric needs would be a poor mea-

44. Joseph P. Grad, *The Preamble of the Constitution of the World Health Organization*, 80 BULL. WORLD HEALTH ORG. 983, (2003).

45. *See generally* WHO, PROMOTING MENTAL HEALTH: CONCEPTS, EMERGING EVIDENCE, PRACTICE (2004).

46. Silvana Galderisi, Andreas Heinz, Marianne Kastrup, Julian Beezhold & Norman Sartorius, *Toward a New Definition of Mental Health*, 14 WORLD PSYCHIATRY 231 (2015) (explaining one such criticism explains that this definition conflates a state of mental health as a state of constant happiness, when in fact, appropriate mental health responses would include, at times, distress or sadness for example after the passing of a loved one).

47. *See Mental Health: Strengthening Our Response*, WHO (Mar. 20, 2018), https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response (describing mental health and mental healthcare separately).

48. *See* WHO, PROJECT ATLAS: MAPPING MENTAL HEALTH RESOURCES AROUND THE WORLD (2001), https://www.who.int/mental_health/evidence/atlasmnh/en/ (explaining the WHO collects data on mental health metrics across the globe every few years. It uses the same criteria, and generally the data is self-reported by the states surveyed).

sure for mental health among the Hmong culture. This paper will point out the more notable instances of a Western approach to mental health in the Variables section.[49]

The DSM-IV, which was considered the official diagnostic reference in psychology and psychiatry in the United States at the time of this study, has been criticized as having limited "cross-cultural utility" resulting from its "limited attention to culturally patterned diversity in phenomenology, risk moderation, and course through excessive reliance on decontextualized epidemiological data."[50] The WHO tracks suicide rates, psychiatric practitioners, dedicated psychiatric hospital beds, and other similar features to measure the mental health burden within a country and the country's capacity to adequately address that burden.[51] Use of terms like "psychiatric" leaves little room to consider alternative treatment modalities to mental health like shamans or other cultural practitioners.

The Western approach to mental health tends to focus on pharmacologic interventions or what some have referred to as "middle class talk therapy."[52] However, there is no magic pill that can remove someone's depression and anxiety if that person is jobless, homeless, and starving. Even if there were, such a medication would not necessarily improve mental health status; someone in this circumstance would probably be described as being mentally unhealthy if they were content while unemployed, homeless, and starving. Practitioners noted in the case of the Beirut explosion that the increased demand for mental health services and the acute incidence of anxiety and depression as a "normal reaction to abnormal events."[53]

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49. *See infra*, Section V(a), *Legal Epidemiologic Analysis: Methods and Variables*.

50. Renato D. Alarcón, Anne E. Becker, Roberto Lewis-Fernández, Robert C. Like, Prakash Desai, Edward Foulks, Junia Gonzalez, Helena Hansen, Alex Kopelpwicz, Francis G. Lu, Maria A. Oquendo & Annelle Primm, *Issues for DSM-V: The Role of Culture in Psychiatric Diagnosis*, 197 J. NERV. MENT. DIS. 559–60 (2009), https://insights.ovid.com/crossref?an=00005053-200908000-00001.

51. *See, e.g.*, WHO, MENTAL HEALTH ATLAS 2017, 2–3 (2018).

52. Yael Latzer, *Traditional Versus Western Perceptions of Mental Illness: Women of Moroccan Origin Treated in an Israeli Mental Health Center*, 17 J. SOC. WORK PRAC. 77, 78 (2003) ("The Israeli psychiatrist is normally the head of a multidisciplinary therapeutic team, and carries the primary responsibility for the treatment of the patient. Typically, the psychiatrist evaluates the patient, prescribes medication if needed, refers the patient to social workers or psychologists in the event that social-rehabilitative treatment or psychotherapy are deemed necessary, and conducts the follow-up.").

53. *Lebanon: Mental Health Needs Support Post-Beirut Explosion*, MEDECINS SANS FRONTIERES: DRS. WITHOUT BORDERS (Oct. 9, 2020), https://www.doctorswithoutborders.ca/article/lebanon-mental-health-needs-support-post-beirut-explosion (noting the difference between the immediate acute impacts of trauma as a normal reaction and the potential for long-term mental health problems to develop if the acute conditions are left untreated).

Pharmacologic interventions can be helpful for many mental health conditions that exist outside of social level factors, and new research has shown that these can be inexpensively acquired.[54] Many conditions do not require specialized training to properly prescribe these treatments.[55] The pharmaceutical interventions alone still leave a gap in mental health attainment because they are culturally insensitive and incapable of remedying life events that contribute to mental health.[56] While some pharmaceuticals may assist in helping someone who is depressed from being or becoming suicidal as a result of their life circumstances, no pharmaceutical can take away the reality of being unemployed, homeless, and starving—all social level factors which can contribute greatly to severe depression and other mental health concerns.[57]

A brief survey of cultural attitudes surrounding mental health demonstrates a wide array of conceptualizations of mental health. Some Native American communities, for instance, focus on wellness as "wholeness of existence" and do not have a concept of "disability," instead focusing on "balance between mind[,] body and spirit," which does not separate mental from physical health.[58] Traditional Hmong culture does not value Western medicine and perceives poor health as a spirit that has been lost, correctable only by shaman rituals.[59] Studies have shown that not only is Western medicine ineffective for many Hmong immigrants in the United States, but it can actually worsen mental health status, since members may forego treatment entirely

54. Vikram Patel & Martin Prince, *Global Mental Health: A New Global Health Field Comes of Age*, 303 JAMA 1976 (2010) (quoting "[E]vidence [has shown that] efficacious drug and psychological treatments are available for a range of mental disorders and that non-specialist health care workers can deliver psychological treatments or multicomponent stepped care interventions for mental disorders, with large treatment effect sizes that are sustained for extended periods.").

55. *Id.*

56. *See* WHO, Soc. Determinants of Mental Health, 20, 28 (2014).

57. Benedetto Saraceno, Melvin Freeman & Michelle Funk, *Public Mental Health*, *in* Oxford Textbook of Public Health 1082 (5th ed. 2009).

58. Marisa Leib-Neri, *"Everything in Nature Goes in Curves and Circles": Native American Concepts of Disability*, Grinnell Col.: Health & Med. in Am. Hist. (July 23, 2015), https://lewiscar.sites.grinnell.edu/HistoryofMedicine/uncategorized/everything-in-nature-goes-in-curves-and-circles-native-american-concepts-of-disability/.

59. Lor Maicho, Phia Xiong, Linda Park, Rebecca J. Schwei & Elizabeth A. Jacobs, *Western or Traditional Healers? Understanding Decision Making in the Hmong Population*, 39 W. J. Nursing Rsch., 400, 417 (2017) ("Temporary soul loss or soul separation is believed to be a factor in the majority of illnesses in Hmong traditional health models. Souls can be separated by accident, by a frightening event, or may be taken by an angered or offended spirit. A shaman is the only healer who can communicate directly with the supernatural spirits responsible for the illness and correct the soul loss.").

over seeking Western treatment or with positive results only arising from the "ua neeb" ritual.[60]

While research has not yet revealed *why* Western approaches are ineffective in other cultures, other studies have ventured hypotheses. One such study explored the role of mental health literacy by examining culturally-based mental health stigma, traditional versus Western mental health care, and help-seeking beliefs in European-decent Americans in the United States and Indians in India.[61] The study found great cultural variance between perceptions of help-seeking behavior and attitudes surrounding causal beliefs.[62] The study concluded that "some cultures . . . rely heavily on traditional and spiritual healers. Because, alternative medicine and spiritual leaders are core sources of help in some cultures, future research should examine [their role]."[63]

The WHO's method of evaluating the status and ability to treat global mental health reveals a Western bias. Granted that the WHO is tasked with the impossible—creating a single system to evaluate all countries on the mental health metric—the measures to evaluate mental health are primarily hospital beds, prescriptions, cases "treated," and psychiatrists.[64]

III. GLOBAL ACTION ADDRESSING MENTAL HEALTH: 1946–2012

While the first action plan to address the global disease burden of mental health was created in 2013,[65] the WHO and international treaties have peripherally addressed mental health since 1946.[66] This section will provide a brief overview of the legal instruments that address

60. Song E. Lee, *Mental Health of Hmong Americans: A Metasynthesis of Academic Journal Findings*, 14 HMONG STUD. J. 1, 14–15, 18 (2013), https://www.hmongstudiesjournal.org/uploads/4/5/8/7/4587788/leehsj14.pdf.

61. Laura Altweck, Tara C. Marshall, Nelli Ferenczi & Katharina Lefringhausen, *Mental Health Lliteracy: A Cross-Cultural Approach to Knowledge and Beliefs About Depression, Schizophrenia and Generalized Anxiety Disorder*, 6 FRONTIERS IN PSYCH. (Sept. 5, 2015), at 1, 2, http://journal.frontiersin.org/Article/10.3389/fpsyg.2015.01272/abstract.

62. *Id.* at 5.

63. *Id.* at 15.

64. *See generally* WHO, *supra* note 51.

65. WHO, *supra* note 16.

66. Comfort Asanbe, Ayorkor Gaba & Jeea Yang, *Mental Health Is a Human Right*, AM. PSYCH. ASS'N (Dec. 2018), https://www.apa.org/international/pi/2018/12/mental-health-rights ("The preamble to the 1946 Constitution of the World Health Organization (WHO) defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.").

mental health, including treaties and charters, with a particular focus on the international instruments included in the legal epidemiologic analysis.

A. The World Health Organization

Over time, the WHO has addressed the global mental health burden in various formats, from the formation of the WHO in its charter to policy and evaluation documents.

1. The WHO Charter

The first instance of recognizing mental health as a human right appears in the founding charter of the WHO, which grants "the right to the enjoyment of the highest attainable standard of physical and mental health."[67] As articulated in the WHO Preamble, the right to health puts a positive obligation on states,[68] defining health as "a state of complete physical, mental and social well-being," distinguishing it from "merely the absence of disease or infirmity."[69] The Preamble further elaborates that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition."[70] While the charter specifically recognizes the right, it fails to define the "highest attainable standard" or how states are to ensure their population realizes the right to mental health. Subsequent WHO documents have, however, provided some guidance.

2. WHO Action on Mental Health as a Human Right

The WHO has touched on mental health and human rights in various documents throughout the past couple of decades and the role of law in addressing mental health.[71] But, until recently, the WHO had no actionable plan to address mental health as a human right—a plan that set global goals and provided action items.

Though created a decade before the Plan itself, the WHO promulgated a Mental Health Policy and Service guidance package[72]

67. WHO, THE RIGHT TO HEALTH, FACT SHEET NO. 31 at 1 (last visited Mar. 5, 2022), https://www.ohchr.org/documents/publications/factsheet31.pdf.

68. Frank P. Grad, *The Preamble of the Constitution of the World Health Organization*, 80 BULL. WORLD HEALTH ORG. 981, 981 (2002).

69. WHO CONST. PMBL. (1946).

70. *Id.*

71. *See generally* WHO, *supra* note 11.

72. *See id.* at 2–3.

designed to encourage countries to improve the status of mental health.[73] One resource in the package was a specific Mental Health Legislation and Human Rights document, which provides a broad framework to assist states with developing mental health legislation.[74] While documents like the Mental Health Legislation and Human Rights guidance document provide useful information for countries to consider adding or modifying their mental health laws, the explanations remain abstract and do not concretely tie legislation and policy to human rights instruments or delineate what features of laws are required to meet a human rights threshold.[75] Instead, the document suggests gaining diverse stakeholder buy-in, surveying the state's existing mental health law, and suggesting priority categories for implementing legislation.[76]

In 2001, the WHO published a report focused on revisiting and reconceptualizing mental health in a global context.[77] The report advocates the integration of mental and physical health, describes the global disease burden of mental health, and guides diagnosing and treating mental health.[78] This report acknowledged the role of policy in addressing global mental health needs:

> Governments, as the ultimate stewards of mental health, need to assume the responsibility for ensuring that these complex activities are carried out. One critical role in stewardship is to develop and implement policy. Policy identifies the major issues and objectives, defines the respective roles of the public and private sectors in financing and provision, identifies policy instruments and organizational arrangements required in the public and possibly in the private sectors to meet mental health objectives, sets the agenda for capacity building and organizational development, and provides guidance for prioritizing expenditure, thus linking analysis of problems to decisions about resource allocation.[79]

73. The distinguishing trait between resources like the Guidance package and the Plan is that the Plan marks the first time the WHO has specifically encouraged countries to improve mental health on a human rights basis. The WHO has a long-established history of encouraging countries to recognize mental health needs and improve available resources but has not done so through a specific and measurable call to action including a plan to address human rights until the creation of the 2013-2020 plan. *Id.*; *see generally* Altweck et al., *supra* note 61.

74. *See* WHO, supra note 11, at 2–4.

75. *See Id*.

76. *Id.* at 40.

77. THE WORLD HEALTH REPORT 2001, *supra* note 13.

78. *Id.*

79. *Id.* at 77.

Though the report encourages strengthening health systems as an important policy priority[80] (which is a Western approach to mental health) it recognizes that community-based interventions[81] may be more responsive to diverse cultural requirements.[82] Both recommendations are consistent with the United Nations resolution, which sets out the basic rights for "mentally ill persons [to] receive treatment in the health care system."[83] And though only one third of one page of the 178-page document discusses mental health legislation,[84] the report explicitly emphasizes the necessity of governments to enact the United Nations resolution by "codify[ing] and consolidat[ing] the fundamental principles, values, and goals of mental health policy" through legislation, or revising outdated legislation.[85]

B. Treaties

The WHO has delineated several international and regional treaties that it believes relate specifically to mental health.[86] Treaty bodies provide helpful, albeit non-binding guidance on the delineated rights which are respected in the international law communities.[87] The next section will describe how each of the instruments identified by the WHO relate to mental health. While the WHO has identified both international and regional agreements, this study only includes the international treaties.[88]

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80. *Id.* at 79.

81. "Community-based" is a frequently used term in public health without a precise meaning. In this paper, the term refers to smaller interventions created with the assistance of those in the community to ensure the intervention reflects the needs of the community and is implemented in a way that will actually benefit that community. This is in contrast to interventions that are developed without the input and assistance of the community itself, and instead are somewhat transplanted into a community. For a thorough discussion of "community-based," *see* Kenneth R. McLeroy et al., *Community-Based Interventions*, 93 AM. J. PUB. HEALTH, no. 4, April 1, 2003, http://ajph.aphapublications.org/doi/10.2105/AJPH.93.4.529.

82. THE WORLD HEALTH REPORT 2001, *supra* note 13, at 84.

83. *Id.* at 84.

84. *Id.*

85. *Id.*

86. WHO, INTERNATIONAL HUMAN RIGHTS INSTRUMENTS RELEVANT TO THE RIGHTS OF PEOPLE WITH MENTAL DISABILITIES, https://www.who.int/mental_health/policy/legislation/un_and_regional_human_rights_instruments.pdf?ua=1.

87. *See generally* Lutz Oette, *The UN Human Rights Treaty Bodies: Impact and Future in* INTERNATIONAL HUMAN RIGHTS INSTITUTIONS, TRIBUNALS, AND COURTS 1–21 (2018).

88. Because regional treaties by design do not have the potential to impact all nations, including such instruments in a broad evaluation like that of this study has the potential to skew the data. For instance, because there is no Asian regional entity, states in Asia would not have the opportunity to agree or to create reservations, while countries in the European Union would have multiple opportunities to sign on to multiple treaties protecting mental health rights.

1. The International Covenant on Economic, Social, and Cultural Rights ("ICESCR")[89]

The International Covenant on Economic, Social, and Cultural Rights ("ICESCR") mirrors the language of the WHO charter and plainly recognizes the right to the "highest attainable standard of physical and mental health."[90] The treaty describes the process of achieving "the full realization of this right" and specifies the "prevention, treatment and control of epidemic, endemic, occupational, and other diseases," along with "the creation of conditions which would assure to all medical service and medical attention in the event of sickness."[91]

The ICESCR grants a right to health resources and health-related freedoms.[92] Because the ICESCR bases its rights in progressive realization, the expectation is that states will work towards achieving that right and other goals within the treaty over time.[93] The right to healthcare services—which are dependent on in-country resources—such as medical services, medical attention, and treatment of disease, indicate a right to health*care* rather than a right to health status; as such, these are subject to progressive realization.[94] The "freedoms" that the ICESCR protects, such as "freedom to control one's health and body and the right to be free from interference, torture and non-consensual medical treatment," are not resource dependent, and therefore should be realized by the people immediately.[95]

When analyzing adherence to the right to health under the ICESCR, Special Rapporteurs broadly construe what actions a country must take to uphold the right to mental health. For instance, a report from the Special Rapporteur assessing the right to health (in-

89. International Covenant on Economic, Social, and Cultural Rights, Dec. 16, 1966, 993 U.N.T.S. 3.

90. *Id.* art. 12(1).

91. *Id.*

92. U.N High Commissioner of Human Rights, *Mental Health and Human Rights*, ¶¶ 6–7, U.N. Doc. A/HRC/34/32 (Feb. 27, 2017–March 24, 2017). The ICESRC also prohibits discrimination. International Covenant on Economic, Social, and Cultural Rights, art. 2(2), Dec. 16, 1966, 993 U.N.T.S. 3. Because the ICESCR explicitly protects mental health, the discussion of the impact of discrimination on mental health is reserved for the ICCPR, which does not explicitly protect mental health. The impact of discrimination on mental health remains the same regardless of which document protects against it. For a thorough discussion on discrimination in the context of the ICESCR, *see* General Comment No. 20 of the UN Committee on Economic, Social and Cultural Rights, International Covenant on Economic, Social and Cultural Rights (2009).

93. *Id.*

94. *Id.*

95. *Id.*

cluding mental health) in Ghana detailed a lack of physical and human resources to treat mental health, problems arising from the stigmatization of mental health, and lack of legislative progress to address mental health.[96] These issues invoke challenges from multiple sectors, including government, education, social services, economics, and transportation.

2. The International Covenant on Civil and Political Rights ("ICCPR")[97]

The ICCPR's role in mental health is less explicit than that of the ICESCR. The ICCPR grants multiple rights and freedoms, such as the "right to liberty of movement and freedom to choose his residence."[98] However, the ICCPR also limits most of these rights and freedoms, but only if "necessary to protect . . . public health or morals . . . and are consistent with the other recognized in the present Covenant."[99]

Beyond protecting the general "public health," the ICCPR's protection of liberty should also be interpreted to include a right to due process before a person is detained based on their mental health needs[100] in the context of mental health, this should mean that individuals cannot be incapacitated or held against their will as a result of their mental health needs without due process of law. Though the ICCPR appears to contemplate deprivations of liberty as arising from criminal accusations, the language of the treaty is broad enough to require due process[101] and humane treatment[102] upon involuntary detention, regardless of the cause. The United Nations Human Rights Committee ("UNHRC") separates rights to liberty from the right to health but requires states to consider the effects of their actions on "physical or mental health."[103] When analyzing arbitrary detention and unlawful detention, the UNHRC specifically addresses involuntary hospitalization for mental health, stating that "[s]tate parties

96. Anand Grover (Special Rapporteur), Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical health, U.N. Doc. A/HCR/20/15, addendum 1 (April 10, 2012).

97. International Covenant on Civil and Political Rights, Dec. 16, 1966, 999 U.N.T.S. 171.

98. *Id.* at art. 12(1).

99. *Id.* at art. 12(3).

100. *Id.* at art. 9(1).

101. *Id.*

102. *Id.* at art. 10(1).

103. General Comment No. 35, Hum. Rts. Committee, ¶ 9, U.N. Doc. CCPR/C/GC/35 (2014).

should revise outdated laws and practices in the field of mental health in order to avoid arbitrary detention."[104]

The ICCPR additionally prohibits discrimination on bases "such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth *or other status*."[105] Though mental health or mental illness is not specifically identified, "other status" indicates that discrimination based on mental health status would be prohibited under the terms of the treaty when considering other UNHCR documents that emphasize that "the principle of non-discrimination" is of "basic and general character."[106] This suggests that "other status" may be interpreted consistent with its plain meaning, that is, *any* other status.

The UNHCR relatedly discusses the definition of "discrimination," ultimately defining it as "*any* distinction, exclusion, restriction or preference which is based on *any* ground *such as* race, colour . . . or *other status*, and which has the purpose or effect of nullifying or impairing the recognition, enjoyment or exercise by all persons, on an equal footing, of all rights and freedoms."[107] Under this definition, "other status" would seem to indicate any status from which it is possible to discriminate, to be understood expansively.

3. Convention on the Rights of Persons with Disabilities ("CRPD")[108]

Perhaps the most protective of documents upholding the rights of those with mental health concerns is the CRPD. Though the term "mental health" is not found in the treaty, the intent is to protect persons with all types of disabilities, whether those impact mental health, physical health, or something else entirely. Article 1 of the CRPD, stating the purpose of the treaty, protects "[p]ersons with disabilities include[ing] those who have long-term physical, *mental, intellectual or sensory impairments* which in interaction with various barriers may *hinder their full and effective participation in society* on an equal basis with others."[109] While mental health is defined, in part, as a state in

104. *Id.* at ¶ 19.
105. International Covenant on Civil and Political Rights, art. 2(1), Dec. 16, 1966, 999 U.N.T.S. 171 (emphasis added).
106. General Comment No. 18, Hum. Rts. Committee, ¶ 3, U.N. Doc. HRI/GEN/1/Rev.9 (1989).
107. *Id.* at ¶ 7 (1989) (emphasis added).
108. Convention on the Rights of Persons with Disabilities, Dec. 13, 2006, 2515 U.N.T.S. 3.
109. *Id.* at art. 1 (emphasis added).

which individuals can participate in society, the CRPD emphasizes the challenges those with mental or other impairments may face to achieving that goal.[110]

Article 25 of the CRPD specifically relates to health protections for persons with disabilities, promoting equality across healthcare access and service provision.[111] Article 26 encourages independence and "full inclusion and participation in all aspects of life."[112] While it is not valuable to describe every article of the treaty here and how it relates to health, suffice it to say that the treaty specifically focused on the rights of the disabled and goes to great lengths to promote equality and access to care for those with any type of disability, specifically including those with mental disabilities.

In interpreting the treaty, country reports and general guidance documents have repeatedly emphasized the importance of removing "legal regimes allowing the institutionalization of persons with disabilities, including persons with intellectual and psychosocial disabilities ('mental illness')."[113] The UNHRC, in addressing the challenges posed by those with mental health conditions, states that "mental health laws, where they exist, should avoid the separate regulation of legal capacity, to the right to liberty and security, or other aspects of the law which are amenable to being mainstreamed into general legislation."[114]

4. Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment ("CAT")[115]

Unlike the CRPD, which protects the rights of those with an existing disability, the CAT protects against the creation of mental suf-

110. WHO, PROMOTING MENTAL HEALTH: CONCEPTS, EMERGING EVIDENCE, PRACTICE (2004).

111. Convention on the Rights of Persons with Disabilities, art. 25, Dec. 13, 2006, 2515 U.N.T.S. 3.

112. *Id.* at art. 26.

113. Concluding Observations of the Committee on the Rights of Persons with Disabilities: Spain, Sixth Session, CRPD/C/ESP/CO/1, at ¶ 35–36 (2011); *see also* General Comment No. 5, of the Committee on the Rights of Persons with Disabilities, CRPD/C/GC/5, at ¶ 48 (2017) (describing the obligation to respect as an "obligation to release all individuals who are confined against their will in mental health services or other disability-specific forms of deprivation of liberty").

114. Addendum to the Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health on Its Twentieth Session, U.N. Doc. A/HCR/20/15/Add.1, at ¶ 42 (2012).

115. *See generally* Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, G.A. Res. 39/46 (Dec. 10, 1984).

fering. Article 1 defines "torture" as "any act by which severe pain or suffering, whether physical *or mental*, is intentionally inflicted on a person" for a variety of reasons.[116] Under this definition—and considering the definition of mental health as a status of health not merely an absence of illness—the CAT serves to protect individuals from experiencing intentional mental distress. The CAT can be understood as an instrument to help individuals achieve the "highest attainable standard" of mental health by removing a device previously used to intentionally degrade mental health.[117]

The Committee Against Torture has explicitly considered the role of torture in impacting mental health in a variety of circumstances.[118] Mr. Ali Ben Salem, a human rights activist in Tunisia, alleged that he was a victim of horrific torture at the hands of the Tunisian police.[119] He specifically urged the Committee to consider the "resulting permanent physical and mental effects of the ill-treatment."[120] With regard to prisons, the Committee has expressed concern for the "insufficient provision of mental health care in prisons and reports indicating that mentally ill inmates are subjected to extensive use of solitary confinement and subsequent increased risk of suicide attempts."[121]

Though first effective in 1987, the United Nations reported in 2008 that the right to be free from torture is so widely recognized that it has become part of customary international law, meaning that even countries who have not joined the treaty are nonetheless bound by it.[122]

116. Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, G.A. Res. 39/46, art. 1 (Dec. 10, 1984).

117. A discussion on the nexus of torture and mental health is outside the scope of this paper. *See* Amanda C de C Williams & Jannie van der Merwe, *The Psychological Impact of Torture*, 7 BR. J. PAIN 101, 102 (2013) (Studying the many ways torture can impact mental health), http://journals.sagepub.com/doi/10.1177/2049463713483596 (last visited Dec. 6, 2019).

118. Ali Ben Salem v. Tunisia, annex, Convention Against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment DEC/269/2005, ¶ 3.1 (2005).

119. *Id.* at ¶ 2.1.

120. *Id.* at ¶ 3.1.

121. Rep. of the Comm. Against Torture, at art. 11 ¶ 23 (b), A/63/44 (May 16, 2008).

122. Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, *General Comment No. 2*, ¶ 1, CAT/C/GC/2 (Jan. 24, 2008).

5. Convention on the Elimination of All Forms of Discrimination Against Women ("CEDAW")[123]

Like the ICCPR, CEDAW presents a more veiled approach to mental health. Though the overarching purpose of CEDAW is to ensure equal rights for men and women, an important component of those rights is the right to health—nowhere mentioned explicitly in the treaty.[124] Nonetheless, CEDAW has been specifically invoked in international tribunals as creating an obligation for states to provide critical mental health services to women in need.

In the tragic case of *L.C. v. Peru*, a young girl was repeatedly raped in her neighborhood.[125] After discovering she was pregnant, she attempted suicide by jumping off a building, but survived.[126] At the hospital, doctors refused to provide a therapeutic abortion or conduct a spine surgery because the girl was pregnant.[127] As a result, the girl became a quadriplegic.[128] The CEDAW committee stated that Peru should "review its laws with a view to establish a mechanism for effective access to therapeutic abortion under conditions that protect women's physical *and mental health*."[129] The Committee further found that the State violated her rights, and was particularly concerned because she "was a minor, a victim of sexual abuse and in poor mental health, as evidenced by her suicide attempt."[130]

While CEDAW does not contain explicit references to health, the contents of CEDAW are designed to promote women's equality, and as such, a necessary component is to ensure women access to mental health resources and provide a culture that values women's mental health as it values men's mental health.

123. *See generally* Convention on the Elimination of All Forms of Discrimination Against Women, G.A. Res. 34/180 (Dec. 18, 1979).

124. *Id.*

125. Comm. on the Elimination of Discrimination Against Women, *L.C. v. Peru,* ¶ 2.1, CEDAW/C/50/D/22/2009 (Nov. 4, 2011).

126. *Id.*

127. *Id.* at ¶ 2.3, ¶ 2.4, ¶ 2.6.

128. *Id.* at ¶ 2.10, ¶ 2.11.

129. *Id.* at ¶ 12(b)(1).

130. Eszter Kismödi, Judith Bueno de Mesquita, Ximena Andión Ibañez, Rajat Khosla & Lilian Sepúlveda, *Human Rights Accountability for Maternal Death and Failure to Provide Safe, Legal Abortion: The Significance of Two Ground-Breaking CEDAW Decisions*, 20 REPROD. HEALTH MATTERS 34 (2012).

6. Convention on the Rights of the Child ("CRC")[131]

Like CEDAW, CRC is not a treaty specifically aimed at promoting mental health; rather, the purpose of CRC is to recognize the importance of protecting children.[132] However, mental health is specifically recognized within the treaty, interestingly as it relates to the mass media.[133] Article 17 describes the ways in which the mass media may help foster mental health in children, as well as the protections it must afford to protect children from "information and material injurious to his or her well-being."[134] In the case of the Lebanon explosion discussed in the introduction, mental health experts specifically cautioned about the damaging impact that news stories and adult conversations may have on children who were traumatized by the explosion.[135]

Though the CRC itself does not define "well-being," significant research has emphasized the role of health in well-being. "[W]ell-being can be seen as synonymous with health in its broadest sense. Thus, health and well-being can be understood as complementary concepts . . . one of the strongest and most consistent findings in behavioral medicine is the relationship between positive emotions and health."[136] Some scholars have specifically commented on the concept of child well-being in the context of CRC, stating that "a child's health is undoubtedly a core aspect of his or her well-being," though ultimately finding that there is not an *unqualified* right to health in the CRC.[137] The association between health and well-being is not limited to physical health; much research has focused on "the relationship between well-being as a self-perceived aspect of mental health . . . ."[138]

Like CRPD, CRC contains an article specifically devoted to the rights of mentally or physically disabled children to, among others,

131. *See generally* G.A. Res. 44/25, Convention on the Rts. of the Child (Sept. 2, 1990).

132. *Id.* at preamble.

133. *Id.* at art. 17.

134. *Id.*

135. Mawad, *supra* note 1.

136. Tim Moore & Frank Oberklaid, *Health and Child Well-being*, HANDBOOK OF CHILD WELL-BEING: THEORIES METHODS AND POLICIES 2259, 2263 (A. Ben-Arieh et al. eds., 2014).

137. Laura Lundy, *United Nations Convention on the Rights of the Child and Child Well-Being*, HANDBOOK OF CHILD WELL-BEING: THEORIES, METHODS AND POLICIES, 2239. 2241 (A. Ben-Arieh et al. eds., 2014).

138. *Id.* at 2286.

facilitate the child's active participation in the community,[139] again reflecting the WHO's definitional language of mental health.[140]

Article 24 grants children the right "to the enjoyment of the highest attainable standard of health,"[141] language that mirrors that of the WHO charter. Understanding that mental health is a component of health, this provision can be read to include the right to the highest attainable standard of mental health. Article 25 provides for the protection of children's physical or mental health.[142] While these provisions are overtly related to mental health, the Committee on the Rights of the Child has elaborated that Article 6 additionally invokes mental health considerations:

> Ensuring survival and physical health are priorities, but State parties are reminded that article 6 encompasses all aspects of development, and that a young child's health and psychosocial well-being are in many respects interdependent. Both may be put at risk by adverse living conditions, neglect, insensitive or abusive treatment and restricted opportunities for realizing human potential.[143]

Though CRC protects children generally, the treaty contains provisions to prevent, protect and foster children's mental health.

IV. THE WHO MENTAL HEALTH ACTION PLAN 2013–2020

The WHO formally developed a plan to address mental health as a human right for the first time in 2013 by creating an action plan to improve global mental health in years 2013-2020.[144] The Mental Health Action Plan, 2013-2020 ("Plan") covers multi-disciplinary[145]

139. Convention on the Rights of the Child, *supra* note 131, at 51 ("State Parties recognize that a mentally or physically disabled child should enjoy a full and decent life, in conditions which ensure dignity, promote self-reliance and facilitate the child's active participation in the community.").

140. *See generally* WHO, *supra* note 45.

141. Convention on the Rights of the Child, *supra* note 131, at 52.

142. *Id.*

143. General Comment No. 7, Committee on the Rights of the Child, CRC/C/GC/7/Rev.1, at ¶ 10 (2005).

144. *See generally* WHO, *supra* note 16.

145. Multi-disciplinary, though lacking one specific, agreed upon definition, is best explained as "different (hence 'multi') disciplines that are working on a problem in parallel or sequentially, and without challenging their disciplinary boundaries." Bernard C. K. Choi & Anita W. P. Pak, *Multidisciplinaitry, Interdisciplinarity and Transdiciplinarity in Health Research, Services, Education and Policy: 1. Definitions, Objectives, and Evidence of Effectiveness*, 29 CLINICAL & INVESTIGATIVE MED. 351, 359 (2006). Multi-disciplinary studies can be thought of more as a "salad" than as a "melting pot." *Id.* at 359–60. While not always the case, in practice, multi-disciplinary often refers to different disciplines within the health realm, such as doctors, nurses, healthcare entities, health departments, and researchers.

and inter-sectoral[146] approaches to human rights, including specific legal and governance provisions.[147] The Plan specifically recognizes that "[m]ental health law . . . should codify the key principles, values and objectives of policy for mental health, for example by establishing legal and oversight mechanisms to promote human rights and the development of accessible health and social services in the community."[148] The Plan further emphasizes that "[p]olicies, plans and laws for mental health should comply with obligations under the Convention on the Rights of Persons with Disabilities and other international and regional human rights conventions."[149]

The Plan also sets specific goals and recommends actions to achieve those goals. As it relates to mental health as a human right, the Plan sets a target that "80% of countries will have . . . *policies/plans* for mental health in line with international and regional human rights instruments (by the year 2020)."[150] The Plan also set a goal that "50% of countries will have . . . laws for mental health in line with international and regional human rights instruments (by the year 2020)."[151] The recommended actions include developing and strengthening existing programs, laws, and regulations, managing resources and budgeting, ensuring stakeholder buy-in from "*all* relevant sectors," and "strengthening and empowering" those with mental disorders.[152] The Plan does not, however, set forth any incentive to

146. Inter-sectoral refers to the inclusion of *all* sectors of society—not just those in health. *Social Determinants of Health*, WHO, https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1 (last visited Mar. 3, 2022).

147. WHO, *supra* note 16, at 12.

148. *Id.*

149. *Id.*

150. *Id.* (emphasis added).

151. *Id.* (emphasis added).

152. *Id.* The text of the specific proposed actions is worth including here.

> POLICY AND LAW: Develop, strengthen, keep up to date and implement national policies, strategies, programmes, laws and regulations relating to mental health within all relevant sectors, including codes of practice and mechanisms to *monitor protection of human rights* and implementation of legislation, in line with evidence, best practice, the Convention on the Rights of Persons with Disabilities, and other international and regional *human rights instruments*,

"RESOURCE PLANNING: Plan according to measured need and allocate a budget across all relevant sectors that is commensurate with identified human and other resources required to implement agreed-upon evidence-based mental health plans and actions," "STAKEHOLDER COLLABORATION: Motivate and engage stakeholders from all relevant sectors, including persons with mental disorders, carers and family members, in the development and implementation of policies, laws and services relating to mental health, through a formalized structure and/or mechanism," and "STRENGTHENING AND EMPOWERMENT OF PEOPLE WITH MENTAL DISORDERS AND PSYCHOSOCIAL DISABILITIES AND THEIR ORGANIZATIONS: Ensure that people with mental disorders and psychosocial disabilities are given a formal role and authority to influence the process of designing, planning and implementing policies, laws and services." *Id.* (emphasis added).

achieve these goals, and the Plan is not binding on any state, calling into question what impact the Plan may have, if any.

While the questionnaires used to evaluate the Plan do not specifically define "policy," they provide guidance in "notes" as to how to answer the questions.[153] For the purposes of the questionnaire, to be considered valid, a policy must have been "approved / published by the Ministry of Health or parliament."[154] Additionally, if the country has a "federated system," then the responses are answered by assessing the policies that affect the "majority of the population in the country."[155] The questionnaire's guidance on "legislation" is more definitional. The Plan states that "[m]ental health legislation refers to specific legal provisions that are primarily related to mental health, which typically focus on issues such as civil and human rights protection of people with mental disorders, treatment facilities, personnel, professional training and service structure."[156] The survey further advises that "[l]aws for mental health may be stand-alone or integrated into other general health or disability laws."[157]

The Plan encompasses much more than just law and policy; it advocates an inter-disciplinary and multi-sectoral approach to understanding mental health as a human right. The Plan advocates that stakeholders across disciplines such as "health, education, employment, judicial, housing, social and other relevant sectors as well as the private sector" are necessary to comprehensively advance mental health.[158] In doing so, the Plan implicitly acknowledges the role that outside factors, such as housing and poverty, may have on mental health.

While this paper focuses only on the goals related to law and policy, it is important to remember that, in keeping with the multi-

153. *See generally* WHO, Mental Health Atlas – 2014 Questionnaire (2014).

154. *Id.* at § 1.

155. *Id.* The notes state

> 1. Policies or plans for mental health may be stand-alone or integrated into other general health or disability policies or plans 2. The mental health policy and/or plan is considered valid if it has been approved / published by the Ministry of Health or parliament 3. If both a mental health policy or plan are available, countries should assess both documents as one entity 4. For countries with a federated system, please refer to policies/plans of the majority of states/provinces or the majority of the population in the country.

Id.

156. *Id.* at § 2.

157. *Id.* Like the policy note, the legislation note also includes a provision that states "[f]or countries with a federated system, the indicator will refer to the laws of the majority of states/provinces within the country." *Id.*

158. WHO, *supra* note 16, at 33.

sectoral approach, laws that focus only on mental health may not be the only relevant laws. Laws and policies that focus on physical health, general wellbeing, income, and other social factors may have an important impact on mental health, but these laws are outside the scope of this study.

A. Evaluating the Plan

As part of the WHO's assessment of how countries address mental health as a human right, the WHO has conducted two country surveys that quantitatively address a country's adherence to mental health as a human right.[159] Countries reported responses in 2014, which established a baseline and again reported responses in 2017.[160] Importantly, the 2014 survey reflected the status of a country's laws in 2013, so at times the surveys may reference data as it existed in 2013, even though it was collected in 2014.[161] These assessments are broad and comprehensive, specifically made to address the WHO Mental Health Action Plan's goals.

1. Policy Questions

Both the 2014 and 2017 questionnaires have a specific segment for "assess[ing] compliance of policy/plan with international human rights instruments."[162] Since the specific items used to assess compliance with international human rights instruments did not change between the surveys, the 2017 survey included an instruction that

159. The WHO has conducted three prior surveys in 2001, 2005, and 2011 which did describe whether a country had a law or policy addressing mental health, however there was no measure which gauged whether the law or policy was in compliance with international human rights instruments. For a description of WHO's Project Atlas, *see* WHO, *supra* note 48. For an example report which describes the law and policy on mental health without addressing human rights, *see Mental Health Atlas 2011: Afghanistan*, WHO, (2011), https://www.who.int/publications/i/item/9799241564359.

160. *See* WHO, *supra* note 51, at 1.

161. While the 2014 questionnaire does not, in the survey instrument, specifically state that it is collecting 2013 data, the 2017 questionnaire makes it clear. For example, the mental health policy or plan segment in the 2017 survey states "If the mental health policy or plan in your country been updated in 2013 or later, please complete the following checklist in order to assess compliance of policy/plan with international human rights." WHO, MENTAL HEALTH ATLAS – 2017 QUESTIONNAIRE § 1.6 (2017).

162. *Id.*; WHO, MENTAL HEALTH ATLAS – 2017 QUESTIONNAIRE § 1.6 (2017), https://www.paho.org/hq/index.php?option=com_docman&view=download&category_slug=4-nmh-surveillance-4270&alias=40931-mental-health-atlas-2017-questionnaire-eng-931&Itemid=270&lang=en; WHO, MENTAL HEALTH ATLAS – 2014 QUESTIONNAIRE § 1.6 (2014), https://www.who.int/mental_health/evidence/atlas/questionnaire_2014_en.pdf?ua=1.

countries should only complete the checklist "[i]f the mental health policy or plan . . . [has] been updated in 2013 or later."[163]

Broadly, the questionnaire asks if the country has a stand-alone mental health policy or a plan in which mental health is integrated, when it was last revised, and the current status of that plan.[164] Next, the WHO asks countries to report the mental health plan's compliance with international human rights instruments by checking off any of the five options that apply to that country's plan.[165] The WHO reports the country's response to the policy or plan question by rating the country on a score of zero to five, which corresponds to how many of the boxes the country checks indicating that their policy or plan is in alignment with international human rights instruments.[166] If a country checks three of five boxes, the WHO reports that the country scores a "3."[167] The WHO does not report which of the five indicators a country has checked.[168] The five criteria are:

> 1.5.1 The current policy/plan promotes the transition towards mental health services based in the community (including mental health care integrated into general hospitals and primary care).
>
> 1.5.2 The current policy/plan for mental health pays *explicit* attention to respect for the human rights of people with mental disorders and psychosocial disabilities and vulnerable and marginalized groups.
>
> 1.5.3 The current policy/plan for mental health promotes a full range of services and supports to enable people to live independently and be included in the community (including habilitation and rehabilitation services, social services, educational, vocational, employment opportunities, housing services and supports, etc.).
>
> 1.5.4 The current policy/plan for mental health promotes a *recovery approach** to mental health care, which emphasizes support for individuals to achieve their aspirations and goals, and the involvement of mental health services users in the development of their treatment and recovery plans.
>
> 1.5.5 The current policy/plan for mental health promotes the participation of persons with mental disorders and psychosocial disabilities

163. WHO, *supra* note 162 (2017 questionnaire).

164. *See* WHO, *supra* note 162, at §§ 1.1–1.4 (referencing both the 2014 and the 2017 questionnaires) .

165. *See* WHO, *supra* note 51, at 15–18.

166. *See id.* at 16.

167. *See id.* at 16–17.

168. *See id.* at 15–17.

> in decision making processes on issues affecting them (e.g. policy, law, service reform).[169]

Though the WHO does not specify which treaties or other international human rights instruments it used to formulate these five criteria, the language of these criteria are reflected in the treaties described in Section III. References to community integration, independence, disabilities, service provisions, and self-determination are themes repeated throughout the treaties.

2. Law Questions

Like the policy/plan question, both the 2014 and 2017 questionnaires have a specific segment for "assess[ing] compliance of legislation with international human rights instruments."[170] Also, like the policy/plan question, the 2017 survey included an instruction that countries should only complete the checklist "[i]f the mental health law . . . [has] been updated in 2013 or later."[171]

The survey then asks whether the country has a stand-alone law for mental health, the year of latest revision, whether mental health legislation is integrated into general health or disability laws, and the status of the law on a scale of not developed or available, to available and fully implemented.[172]

Then, the survey asks questions about legislation that parallels that of the policy indicators.[173] There are five indicators that countries self-report whether their law adheres to or not.[174] The WHO reports the countries' responses to this question like the policy question, on a scale of 0–5 based on the number of items the country reports as "yes."[175] The five criteria are:

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169. *See* WHO, *supra* note 162, at, § 1.5 (referencing both 2014 and 2017 questionnaires). The asterisk indicates that this is a term defined in the glossary of the survey. WHO, *supra* note 162, at 2 (referencing both 2014 and 2017 questionnaires). Recovery approach is defined in the glossary as "From the perspective of the individual with mental illness, recovery means gaining and retaining hope, understanding one's abilities and disabilities, engaging in an active life, and having personal autonomy, social identity, meaning and purpose in life, and a positive sense of self. Recovery is not synonymous with cure." WHO, *supra* note 162, at 19 (referencing both questionaires).

170. WHO, *supra* note 162, at § 2.3 (referencing the 2017 questionnaire); WHO, *supra* note 162, at § 2.5 (referencing the 2014 questionnaire).

171. *Id.*

172. *See id.* at §§ 2.1–2.4.

173. *Id.*

174. WHO, MENTAL HEALTH ATLAS – 2014 QUESTIONNAIRE § 2.5 (2014), https://www.who.int/mental_health/evidence/atlas/questionnaire_2014_en.pdf?ua=1.

175. *Id.*

> 2.5.1 Current legislation promotes the transition towards mental health services based in the community
> 2.5.2 Current legislation promotes the right of persons with mental disorders to exercise their *legal capacity**, and to nominate a trusted person or network of people to support them in discussing issues and making decisions
> 2.5.3 Current legislation promotes alternatives to coercive practice; these alternatives include voluntary admission, informed consent to treatment and substitutes for *seclusion and restraints**
> 2.5.4 Current legislation provides for procedures to enable people with mental disorders and psychosocial disabilities to protect their rights and file appeals and complaints to an independent legal body.
> 2.5.5 Current legislation provides for regular inspections of human rights conditions in mental health facilities by an independent body.[176]

The survey does not specify from what international instruments these criteria are gathered. However, clear references are made to the CRPD, including the definition of legal capacity and the right to self-determination encompassed throughout the above categories.[177]

With an understanding of the Plan, particularly, how the Plan evaluates countries' adherence to international human rights treaties through law and policies, the next section will combine the legal and policy data from the WHO with country health outcomes and international instruments to better understand the Plan's successes and shortcomings, and the role that law may play.

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176. *Id*. (emphasis added). The asterisk indicates that this is a term defined in the glossary of the survey. *Id.* at Instructions for Filling Out the Questionnaire. The definition for Legal Capacity reads

> The UN Convention on the Rights of Persons with Disabilities recognizes that people with disabilities, including mental disabilities, have the right to exercise their legal capacity and make decisions and choices on all aspects of their lives, on an equal basis with others. The Convention promotes a supported decision-making model, which enables people with mental disabilities to nominate a trusted person or a network of people with whom they can consult and discuss issues affecting them.

Id. at Glossary. Seclusion is defined as "the voluntary placement of an individual alone in a locked room ore secured area from which he or she is physically prevented from leaving," and Restraint "means the use of a mechanical devise or medication to prevent a person from moving his or her body." *Id.* The definition goes on to state that "[a]lternatives to seclusion' include the prompt assessment and rapid intervention in potential crises; using problem-solving methods and/or stress management techniques such as breathing exercises." *Id.*

177. The Glossary begins the definition of "legal capacity" with "The UN Convention on the Rights of Persons with Disabilities recognizes that people with disabilities, including mental disabilities, have the right . . . ." WHO, MENTAL HEALTH ATLAS – 2014 QUESTIONNAIRE Glossary (2014), https://www.who.int/mental_health/evidence/atlas/questionnaire_2014_en.pdf?ua=1.

V. LEGAL EPIDEMIOLOGIC ANALYSIS

Legal epidemiology is defined as the "scientific study of law as a factor in the cause, distribution, and prevention of disease and injury in a population."[178] This paper incorporates legal epidemiologic approaches to assessing the impact of the Plan. By using country health data, country self-reports of adherence to international human rights instruments, and identifying the signatory status, and reservations made to those same instruments, the impact of the Plan can be better analyzed. This section will describe what variables were used and why, how treaties were selected and coded, and provide an aggregate overview of the countries' results.

A. Methods and Variables

The time-frame for the Plan has ended. While 2020 data is available, the pandemic likely impacted the mental health trajectories for countries, so this analysis uses the 2017 mid-point data to address progress under the Plan. As WHO considers the next steps for protecting mental health post-pandemic, now is the proper time to assess the Plan's impact on laws and policies that recognize mental health as a human right and whether those laws and policies improved mental health within a nation.

First, it is important to set expectations correctly. There are a few important considerations:

- States self-report their compliance with international human-rights instruments by selecting which of five features their law and policy contains. States are not asked for a citation to their law or policy, the text of their law or policy, or some other mechanism by which data reviewers could independently gauge the states' adherence to their mental health laws and policies. Therefore, the data relating to how well a law or policy adheres to international human rights instruments is only as accurate as the states' perception and honesty regarding their laws.
- It is possible that some states may have changed their law or policy prior to 2013, and perhaps even as a result of discussions surrounding the Plan, to score more favorably on the initial baseline evaluation. Alternately, some states may have already

178. Scott Burris, Marice Ashe, Donna Levin, Matthew Penn & Michelle Larkin, *A Transdisciplinary Approach to Public Health Law: The Emerging Practice of Legal Epidemiology*, 37 ANNU. REV. PUB. HEALTH 135–148 (2016), http://www.annualreviews.org/doi/10.1146/annurev-publhealth-032315-021841 (last visited Dec 6, 2019).

had laws and policies that were in perfect compliance prior to 2013, and therefore had no need to amend their law or policy.
- Not every state responded to surveys in both the baseline year and 2017. Data was included even if the state did not respond in both years and was recorded as "none or not reported" if the state did not respond to the survey at all, did not respond to any specific questions, or if data was otherwise unavailable.

With these limitations in mind, the next section will discuss which variables were included in the study and why these variables were included.

1. Non-Calculated Variables

- Year variables: Both the year that the law was last updated and the year that the policy was last updated were recorded. This variable primarily served to indicate which countries were examined further.
- Law: Both the baseline and the 2017 law "score" on a scale of 0 to 5. While it is theoretically possible for a state to score themselves as "0," no state self-scored as "0." The Atlas from which this data was compiled defines "mental health legislation" for the purposes of the variable calculation as "Legal provisions related to mental health. These provisions typically focus on issues such as: civil and human rights protection of people with mental disorders, treatment facilities, personnel, professional training, and service structures."[179]
- Policy/plan: Both the baseline and the 2017 policy "score" on a scale of 0 to 5. While it is theoretically possible for a state to score themselves as "0," no state self-scored as "0." The Atlas from which this data was compiled defines "mental health plan" as "A detailed scheme for implementing strategic actions that address the promotion of mental health, the prevention of mental disorders, and treatment and rehabilitation. Such a plan allows the implementation of the vision, values, principles and objectives defined in the policy." The Atlas defines a "mental health policy" as "an organized set of values, principles and objectives for improving mental health and reducing the burden of mental disorders in a population. It defines a vision for future action."[180] Importantly, a mental

179. WHO, *supra* note 51.
180. *Id.*

health policy is typically "an official statement of a government,"[181] so while it does not have binding legal value, it can be a persuasive tool to either encourage the adoption of mental health laws or encourage enforcement of existing laws. Similarly, the mental health plan is the detailed report that provides the mechanism by which laws and policies will be implemented.[182]

- Disease burden measures: While it would be next to impossible to track the exact disease burden of mental health within each state, the WHO has compiled certain official estimates. For this paper, the purpose of these estimates is to approximate the proportional weight of disease in each state and to determine whether this rate has changed over time.
    - Disability-adjusted life years (per 100,000 population) ["DALYs"]: This variable is calculated by the WHO specifically as it relates to mental health, by adjusting life expectancy (based on changing life-expectancy tables) for the years of life lost due to disability and also adjusting for quality of life lost, converted into years, for disability.[183] Because this variable looks at the entirety of an essentially chronic disease over time, it is unlikely that DALYs will change over a span of just three years. However, this indicator is useful to understand the burden of mental health within individual states and compare that burden between states.

181. *Id.*

182. *Id.*

183. Consider, for example, a 65-year-old man who is beginning to show signs of Lewy Body Dementia. The man, prior to this point, was perfectly healthy and was expected to live to age 80 based off his present health and economic status. However, this particular type of dementia is aggressive and because of its Parkinson's like symptoms, significantly decreases life expectancy. *Dementia with Lewy Bodies*, MEDLINE PLUS (last updated Nov. 24, 2021), https://medlineplus.gov/genetics/condition/dementia-with-lewy-bodies/. The man is now expected to die at age 70. Accounting for the decrease in life expectancy, the man's adjusted life lost is now 10 years. The next step is to account for his *quality*-adjusted life years. Because Lewy Body severely deteriorates mental capacity, and for the simplistic purposes of this example, we can assume that the man will lose 20% of his quality of life in year one, 40% in year two, 60% in year 3, 80% in year 4, and 100% in year 5. Therefore, the man will lose an additional .2+.4+.6+.8+1=3 life years, when adjusted for quality. Overall, the man's disability adjusted life years lost is 13 years. For a thorough explanation of DALYs and how the WHO computes DALYs, *see* WORLD HEALTH ORGANIZATION, *WHO, Methods and Data Sources for Country Level Causes of Death 2000-2016* (2018). While there may have been minor changes to the weights of variables included in computing DALYs, these changes are not significant for the purposes of this analysis.

- Suicide mortality rate (per 100,000 population): This variable is calculated as the rate of suicide, defined as the number of deaths by suicide per 100,000 population.[184] Because suicide is an acute event for which there may be immediate interventions, this variable is more likely to be responsive to laws and policies than DALYs are. However, dramatic changes in suicide rate are unlikely because suicide often results from depression, which is a chronic disease from which individuals suffer from their entire life.
- Capacity measures: Two "proxy" variables were reported to gauge a state's ability to respond to the mental health needs within their states. After thoughtful consideration, these indicators were selected as the best representation of how able a country is to meet a diverse array of mental health needs within its borders and were also reported as part of the baseline and 2017 surveys. Nonetheless, these variables present a Western conceptualization of mental health treatment.
- Total Mental Health Workers per 100,000 Population: The WHO defines this variable as the number of mental health professionals working in the country across disciplines, including psychiatrists and other medical doctors who address mental health, nurses, psychologists, social workers, occupational therapists, and other paid individuals who engage in mental health patient care.[185] This measure was included over other measures of mental health workforce because of the cultural variation in recognizing, treating, and caring for mental health needs. While the WHOs collection of data for this category emphasizes Western conceptualizations for mental health workers, such as psychiatrists and psychologists, the category is broad enough to en-

184. For a thorough explanation of how the WHO computes country-level suicide and other causes of death, *see id.*

185. *See* WHO, *supra* note 51.

compass traditional healers and other culturally-specific providers of mental health care.

- Severe Treated Cases per 100,000 Population: This variable addresses the number of severe cases of mental illness treated within a state as a portion of the population.[186] Severe cases treated was selected over number of facilities, beds, or admissions because not all cases of severe mental illness require hospitalization. Furthermore, not all cultural conceptualizations of mental illness are addressed in a clinical Western-style in-patient setting. However, given that mental illness is typically chronic, all variables attempting to address the success of treating patients with mental health needs are flawed, since unlike something that is acute, like treating the flu, those with chronic mental health needs will likely need to be treated more than once.

2. Calculated Variables

In all categories, simple "change" variables (calculated as *n* in 2017 data minus *n* in baseline data) were created to simply demonstrate what, if any change occurred. Additionally, averages, ranges, and other basic descriptive statistics were calculated for all variable categories.

3. Treaties as Variables

Treaties were included as variables. The treaties chosen are those the WHO has identified as being relevant to mental health as a human right—the same ones described in Section III.[187] For this analysis, each country was "coded" on four different treaty variables for each treaty.

Question 1: Is the country a signatory to this treaty?

First, a country was coded as having either signed or not signed the treaty. This measure is very straightforward. If a country is recorded as a signatory to a treaty—regardless of whether that country ratified the treaty—the country was coded as "yes" to this question.

186. *Id.* at 41.
187. WHO, *supra* note 86.

The purpose of this variable is to understand who the original parties were to agree to the terms of the treaty, and to track any states that signed but never ratified the treaty.

Question 2: In what year did the country either ratify or accede to this treaty?

Second, the year the treaty was ratified or the year in which the country acceded to the treaty was recorded. The purpose of this variable is to understand, for the countries which have agreed to be bound by a treaty, how long this treaty has been in force with respect to that country. For instance, if a country indicated that between 2013 and 2017 the country's mental health legislation is in greater compliance with international human rights instruments, perhaps changing its self-reported score from 3 to 4, and in 2015 the same country acceded to the Convention on the Rights of Persons with Disabilities, there is a logical inference that a country may have changed their law *in response* to an international agreement to which they were previously not a party. Because both ratification and accession have the force of law, no distinction was necessary for this variable. If a country had signed but not ratified, or had not signed or otherwise acceded to the treaty, this response was coded as "n/a," and the third and fourth questions were coded as "n/a."

Question 3: Does the party *presently* hold a relevant reservation or declaration to the treaty?[188]

Third, countries were coded as to whether that country had made a reservation or declaration[189] to that treaty, which could limit that treaty's application regarding mental health. This particular coding question was the most nuanced and most interpretive. Thus, a series

188. Some countries had reservations at signing, or other times in the past, and have since removed those reservations. Only reservations presently in force were considered for this project.

189. The United Nations defines a reservation as

> a declaration made by a state by which it purports to exclude or alter the legal effect of certain provisions of the treaty in their application to that state. . . . Reservations can be made when the treaty made when the treaty is signed, ratified, accepted approved or acceded to. Reservations must not be incompatible with the object and the purpose of the treaty. . . .

Glossary of Terms Relating to Treaty Actions, U.N. TREATY COLLECTION, https://treaties.un.org/Pages/Overview.aspx?path=overview/glossary/page1_en.xml. A declaration is a country's "understanding of some matter or as to the interpretation of a particular provision. Unlike reservations, declarations merely clarify the state's position and do not purport to exclude or modify the legal effect of a treaty." *Id.*

of rules were constructed to ensure scientific integrity and objectivity. Countries which did not have *any* reservations to that treaty were coded as "no." Next, the reservations and declarations for the remaining countries were carefully read, scrutinized, and coded.

All objections were categorically excluded, because a country's statement of disagreement with a *different* country's reservation should not have a bearing on that country's own adherence to mental health as a human right.[190] Additionally, reservations or declarations that might expand a country's interpretation of mental health as a human right beyond that provided for in the treaty[191] was not coded as a relevant reservation or declaration, since the purpose of this study is to understand how to attain the *highest attainable standard* of mental health and specifically the barriers to that attainment. Declarations or reservations that applied only to a specific subset of the population were also excluded as not relevant, because the potential population affected would be so small as to not make the reservation a likely cause that a country would lack high adherence to mental health policy and laws.[192]

Some seemingly similar reservations were coded differently; the reasoning relates directly to the applicability of that reservation to mental health. For instance, Saudi Arabia and the United Arab Emir-

190. For an example of such objections that were excluded, see Norway's and the Netherlands' objections to other countries' reservations to the International Covenant on Economic, Social, and Cultural Rights, International Covenant on Economic, Social, and Cultural Rights, 993 U.N.T.S. 3 (Dec. 16, 1966).

191. Georgia, for example, has a declaration to the Convention on the Rights of Persons with Disabilities that states, "Georgi interprets article 12 of the Convention in conjunction with respective provisions of other international human rights instruments and its domestic law and will therefore interpret its provisions in a way conferring the highest legal protection for safeguarding dignity, physical, psychological and emotional integrity of persons and ensuring integrity of their property." Convention on the Rights of Persons with Disabilities, 2515 U.N.T.S. 3 (Dec. 13, 2006). In this Declaration, Georgia expands the protections provided to persons with disabilities (potentially also including those with mental health needs). *Id.* Because this provision goes above and beyond what is called for in the treaty and does not diminish any portion of the treaty's application to that country as relative to other countries without that reservation, this provision was coded as not relevant.

192. For instance, Japan and Greece have specific reservations that apply only to a sub-population in the Convention on the Rights of Persons with Disabilities. Convention on the Rights of Persons with Disabilities, 2515 U.N.T.S. 3 (Dec. 13, 2006). Greece reserved that the country is not bound by specific employment discrimination provisions as it relates to employment in the military. *Id.* Japan reserved that some provisions do not apply specifically to children who are separated from their parents as a result of deportation. *Id.* While both of these reservations might impact the right to mental health, the portion of the population that would fall into the categories outlined by the countries *and also* have mental health needs represents a portion too small to include for the purposes of this study. Accordingly, these reservations and others like it were coded as not relevant.

ates ("UAE") both hold religious reservations to CEDAW. Saudi Arabia's reservation is broad, stating in part that "In case of contradiction between any term of the Convention and the norms of Islamic [*sic.*] law, the Kingdom is not under obligation to observe the contradictory terms of the Convention."[193] By contrast, though the UAE listed religious objections to the treaty, they listed specific provisions of the treaty in which potential conflict arose, rather than leaving the reservation broadly open to any provision at all.[194] Because none of the specific provisions the UAE listed related to mental health, they were coded as "no" for this question. Saudi Arabia, however, was coded as "yes," because the reservation was so broad that it could apply to any and all of the provisions of the treaty.

Treaty reservations that applied to a provision that impacted health were not automatically coded "no." Instead, the reservation was compared to the relevant provision to see if that reservation could actually impact mental health. For instance, both Argentina and China held reservations to a provision of the CRC.[195] However, both countries limited their reservation only to a portion of the provision which concerned education for family planning.[196] While it is possible that the reservation could impact mental health, the reservation is too narrowly construed and too distanced from the right of mental health to include for this study. Therefore, both countries' reservation was coded as "no."

Question 4: What is the relevant text of the reservation?

For countries for which there was no year the treaty became binding upon them, or countries which did not have a relevant reservation, this question was coded as "n/a." For countries where it was determined there was a relevant reservation, this relevant text was entered. Not all reservation or declaration text was relevant to the question of mental health, so only the portion of the reservation or declaration which related to mental health was included.

193. Convention on the Elimination of All Forms of Discrimination Against Women, 1249 U.N.T.S. 13 (Dec. 18, 1979).
194. *Id.*
195. Convention on the Rights of the Child, 1577 U.N.T.S. 3 (Sept. 2, 1990).
196. *Id.*

B. Data Summary

A total of 190 countries created reports for the Mental Health Atlas either in 2013 or 2017 and were included. Thirty-three countries reported creating or changing their law in 2014 or later.[197] Ninety-one countries reported creating or changing their policy in 2014 or later.[198] Because 20 states reported both changing their policy and their law in 2014 or later,[199] a total of 104 states reported a change in their policy, law, or both.

Policy/plan:

Of the countries that modified their policy or plan, 65 reported survey results to the WHO for both the baseline data and the 2017 report.[200] Of those, 16 self-reported greater compliance with international human rights instruments.[201] Seventy-three countries reported no change from the baseline to 2016.[202] Twenty-one countries re-

197. Belarus, Belgium, Brunei Darussalam, Croatia, Denmark, Estonia, Finland, Gabon, India, Islamic Republic of Iran, Israel, Japan, Kyrgyzstan, Liberia, Mexico, Morocco, Nauru, Netherlands, Norway, Papua New Guinea, Philippines, Qatar, Republic of Korea, Romania, Russian Federation, Saudi Arabia, Sierra Leone, Slovakia, Sri Lanka, Sudan, Tajikistan, United Arab Emirates, Uzbekistan, and Vanuatu.

198. Afghanistan, Argentina, Armenia, Austria, Bahrain, Barbados, Belarus, Belgium, Belize, Bhutan, Bosnia and Herzegovina, Burkina Faso, Burundi, Cabo Verde, Cameroon, Chad, China, Cook Islands, Denmark, Dominican Republic, Ecuador, Egypt, Eritrea, Estonia, Ethiopia, Fiji, Gambia, Georgia, Greece, Grenada, Guatemala, Guinea, Guyana, Haiti, Hungary, Iceland, India, Indonesia, Islamic Republic of Iran, Iraq, Jamaica, Japan, Kenya, Kiribati, Kyrgyzstan, Lebanon, Liberia, Lithuania, Maldives, Marshall Islands, Mauritius, Monaco, Mongolia, Montenegro, Mozambique, Netherlands, Nicaragua, Niger, Norway, Oman, Paraguay, Philippines, Republic of Korea, Republic of Moldova, Former Yugoslav Republic of North Macedonia, Romania, Russian Federation, Sao Tome and Principe, Senegal, Sierra Leone, Slovakia, Slovenia, Spain, Sri Lanka, Sweden Switzerland, Syrian Arab Republic, Thailand, Republic of Macedonia, Timor-Leste, Togo, Tonga, Trinidad and Tobago, Uganda, United Arab Emirates, United Kingdom of Great Britain and Northern Ireland, Republic of Tanzania, United States of America, Vanuatu, and Yemen.

199. Belarus, Belgium, Denmark, Estonia, India, Islamic Republic of Iran, Japan, Kyrgyzstan, Liberia, Netherlands, Norway, Philippines, Republic of Korea, Romania, Russian Federation, Sierra Leone, Slovakia, Sri Lanka, United Arab Emirates, Vanuatu.

200. Some states reported a change in their policy since 2013 but did not report a score for the policy or plan in one or both years.

201. Burkina Faso, Oman, and Togo reported an increase by 4 points. Jamaica, Mozambique, Philippines, Romania, Syrian Arab Republic, and Tonga reported an increase by 2 points. Afghanistan, Bahrain, Burundi, Cook Islands, Iraq, Slovenia, and Sweden reported an increase by 1 point.

202. Argentina, Austria, Barbados, Belgium, Belize, China, Dominican Republic, Ecuador, Ethiopia, Fiji Gambia, Georgia, Greece, Grenada, Guatemala, Guinea, Guyana, Hungary, India, Indonesia, Japan, Kenya, Liberia, Lithuania, Marshall Islands, Monaco, Montenegro, Republic of Korea, Russian Federation, Sierra Leone, Spain, Thailand, The Former Yugoslav Republic of Macedonia, Trinidad and Tobago, Uganda, United Arab Emirates, United States of America, and Vanuatu.

ported a decrease in compliance with international human rights instruments by a factor of one.[203]

Law:

Forty-five states modified their mental health law in 2013 or later; of these, 26 self-reported the law's compliance with international human rights instruments in both the baseline year and 2017. Seven states reported improved scores from the baseline to 2017.[204] Fourteen states reported no change in the score of their law.[205] Five states reported a decrease in the law's compliance with international human rights instruments.[206]

Disability-Adjusted Life-Years[207]:

In the baseline year, the WHO reported DALYs for 139 countries. In 2017, the WHO reported DALYs for 149 countries. A total of 122 countries had DALYs for both years. The average DALY in the baseline year was 3119 years lost per 100,000 population, which decreased in 2017 to 3092, representing a 0.87% change. In the baseline year, the range spanned 3729 DALYs, from 1882 in Burkina Faso to 5611 Belarus,[208] with a median of 3021. In 2017, the range spanned 3757 DALYs, from 1882 in Burkina Faso to 5640 in Estonia,[209] with a median of 3026. The difference between the country with the most disease burden to the country with the least disease burden increased from the baseline to 2017. The range demonstrates that the country with the lowest disease burden remained low, but the gap widened, so

203. Colombia reported a decrease of 3 points. Poland reported a decrease of 2 points. Albania, Armenia, Bhutan, Bosnia and Herzegovina, Denmark, El Salvador, Finland, Iceland, Iran, Jordan, Lebanon, Mexico, Federated States of Micronesia, Pakistan, Paraguay, Qatar, Sao Tome and Principe, Timor-Leste, and Yemen each reported a lower score in 2017 than the baseline. Interestingly, each of these states initially scored themselves as a 5 at the baseline, except Bhutan and Colombia, which originally reported scores of 4.

204. India reported an increase of 4. Belgium, Colombia, and the Czech Republic, reported an increase of 2. Brunei Darussalam, the Cook Islands, and Finland each reported an increase of 1.

205. Croatia, Denmark, Iran, Israel, Japan, Montenegro, Morocco, Romania, Russian Federation, Saudi Arabia, Serbia, Sudan, Tajikstan, and Vanuatu.

206. Austria and China reported a decrease of 1. Iraq, Mexico, and the Republic of Korea each reported a decrease of 2.

207. Because this variable is calculated by averaging values over time, the states' scores did not change much between the baseline year and 2017. It would be misleading to insinuate that changes in DALYs are directly related to the Plan. In fact, the correlation coefficient was 0.99 between the DALYs for the baseline and 2017 data years. Therefore, this variable was not analyzed as a change between the two years.

208. No DALY rate was available for Belarus in 2017.

209. No DALY rate was available for Estonia in the baseline year.

the disease burden increased in countries that already had a high disease burden. However, the proportion of countries with a high disease burden decreased from the baseline to 2017, as evidenced by the lower median. Results are summarized in Table 1.

TABLE 1, Disability-Adjusted Life-Years

	Baseline Year: 2013 n=139	2017 n=149
Range	1882 – 5611	1882 – 5640
Mean	3119	3092
Median	3021	3026

Suicide Rate[210]:

The WHO reported suicide rate estimates for 137 states in the baseline year, 159 states in 2017, and 119 states for both years. The average suicide rate in the baseline year was 9.7 deaths by suicide per 100,000 people in 2013, which decreased slightly by 6.2% to 9.1 deaths by suicide per 100,000 people in 2017. In the baseline year, the range spanned 34.4 deaths, from the lowest rate of 0.4 in Saudi Arabia to the highest rate of 34.8 in Guyana, with a median of 8.2, indicating that the distribution of the suicide rates was skewed low. In 2017, the range decreased, spanning 31.4 deaths per 100,000 people, from the lowest rate of 0.5 in Antigua and Barbuda to the highest rate of 31.9 in Lithuania, with a median of 7.8. In essence, the overall suicide rate decreased globally between the baseline year and 2017. A small number of states have very high rates of suicide, but most states have a lower rate. Results are summarized in Table 2.

210. While the suicide rate does not change dramatically from year to year, as described earlier it is a variable more responsive to immediate interventions. The correlation coefficient for the two years was 0.67, demonstrating a moderate correlation of statistical value, but not indicating a nearly identical dataset like in the case of the DALY variable. This also indicates that the suicide variable may be more susceptible to responsive change.

TABLE 2, Suicide Rate

	Baseline Year: 2013 n=137	2017 n=159
Range	0.4 – 34.8	0.5 – 31.9
Mean	9.7	9.1
Median	8.2	7.8

Mental Health Workers per 100,000 Population:

In the baseline year, 102 countries reported responses for mental health workers per 100,000 people. In 2017, 141 countries reported. Seventy-nine countries reported in both years. The range was narrower in the baseline year (spanning 318.5) than in 2017 (spanning 405.37). The mean was lower in the baseline year (33.2 versus 39.2, 18% increase), while the median was higher (13.4 versus 8.9, 33.6% decrease). Because of the significant increase in the number of reporting countries, it is unclear if the increase in the mean is due to simply more reports or a factual increase in the number of workers per 100,000 people. The change in mean and median indicates a high proportion of states have either very few or very many mental health workers per 100,000 people. Results summarized in Table 3.

TABLE 3, Mental Health Workers per 100,000 Population

	Baseline Year: 2013 n=102	2017 n=141
Range	0.1 – 318.9	0.04 – 405.41
Mean	33.2	39.2
Median	13.4	8.9

Severe Treated Cases per 100,000 Population:

In the baseline year, 64 countries reported the number of severe cases treated. In 2017, 70 countries reported data. Only 32 countries reported in both years. The range spread increased dramatically between the two years, in large part due to an outlier, Brazil, which reported 73,757 severe treated cases per 100,000 people, which is significantly higher than the next highest reporting country, Monaco,

which reported 2,594 severe treated cases per 100,000 people.[211] Interestingly, the mean decreased by 2.1% from 578.7 to 566.1, while the median increased significantly by 150%, from 127.5 to 318.27. Like the previous variable, the difference in number of countries reporting between the two years may have artificially created this difference. Results are summarized in Table 4.

TABLE 4, Severe Treated Cases per 100,000 Population

	Baseline Year: 2013 n=64	2017 n=70
Range	1.3 – 4603	2.6 – 73757
Mean	575	1634
Median	n/a	n/a

VI. DISCUSSION

In reviewing the data, there were some implied relationships. For instance, change in treatment capacity was strongly associated with change in workforce capacity (r = 0.87). While this result is unsurprising, it confirms expected relationships which indicates a degree of data validity.

More surprisingly, the change in suicide rate was moderately correlated with the change in treatment rate (r = 0.61). On numbers alone, this association would indicate that the number of suicides increased as the availability of treatment increased—a paradoxical relationship. This relationship may more accurately indicate a change in reporting of suicides and may serve as a proxy for a state's awareness of suicide. With an increase in access to mental health treatment, the state may be more aware of suicide as a cause of death. As a result, the state may report increased numbers of suicides, which were previously categorized as other causes of death. While this premise is not provable, it is more logical than suggesting that an increase in providers *causes* an increase in rates of suicide.

211. Most likely, Brazil's data point is a reporting error. Treating 73,757 *severe* cases per 100,000 would indicate that 74% of Brazil's population had a severe mental condition requiring treatment. Additionally, in 2013 Brazil reported treating 473 severe cases per 100,000 population. At face value, the change between the baseline and 2017 reporting year represents over 155 times the number of severe treated cases. However, without more data, the true rate of Brazil's severe treated cases cannot be ascertained. Since this analysis uses exclusively the WHO data, the values were retained for Brazil as reported by the WHO.

A few moderate correlations were uncovered in the data. While moderate correlations do not guarantee a causal relationship, they do suggest a relationship. Importantly for this study, some of these correlations imply a "cause and effect" type of relationship.

Interestingly, the amount by which a state reported its law changed was moderately associated with the change in the treatment capacity ($r = 0.65$) and the change in workforce capacity ($r = 0.58$). This result indicates that states which reported the greatest increase in compliance to international human rights instruments also experienced the greatest increase in their ability to meet the states' mental health treatment needs, in terms of number of cases treated and having the workforce available to provide treatment. It also indicates that states which reported decreases in the law's compliance with international human rights instruments experienced decreases in the ability to meet the mental health needs within the state.

To gain a better understanding of the nuanced relationships between changes in law and policy, and changes in health, sub-groups of states were analyzed.

A. States That Reported an Improvement in Law

In this sub-group, only states that reported an improvement in the law's adherence to human rights between the baseline year and 2017 were analyzed. Fifteen countries self-reported improvement in how well its laws aligned with international human rights instruments: Afghanistan, Belgium, Bhutan, Brunei Darussalam, Burkina Faso, Colombia, Cook Islands, Costa Rica, Czech Republic, Finland, India, Indonesia, Senegal, South Africa, and Swaziland. Interestingly, of these ten, only four reported an improvement in their policy; five reported no change at all, and three reported a *decrease* in their adherence to human rights instruments.[212]

These countries span nearly the entire range of the disease burden, from a low DALY in Brunei Darussalam to a high DALY in Afghanistan. By contrast, the suicide rates of these countries clustered towards the low to middle range of the spectrum. In seven of these countries, the suicide rate decreased, but in seven other countries the rate increased.

212. Senegal did not report a policy score in 2013, so it is unclear if its score would have improved, decreased, or remained constant.

The workforce capacity increased in seven states and decreased in two; though in Indonesia and Senegal, where the capacity decreased, the decrease was small (decreasing by only 0.1 and 0.48 workers per 100,000 people).

Out of all the sub-groups, the group that reported that improving its law was proportionately least likely to be bound by international human rights treaties affecting mental health. Therefore, it was most likely to have room for improvement and take advantage of that opportunity. The percent of countries that had ratified each treaty was lower than any other sub-group in all but one treaty—the CRPD—where this subgroup was second to last. Two-thirds of these countries have ratified the CAT, and three-quarters have ratified the ICESCR and ICCPR.

Notably, two countries ratified the CRPD since 2013: Finland and Brunei Darussalam.[213] Interestingly, Brunei Darussalam has an expansive reservation to the CRPD which states that "The Government of Brunei Darussalam expresses its reservation regarding those provisions of the said Convention that may be contrary to the Constitution of Brunei Darussalam and to the beliefs and principles of Islam, the official religion of Brunei Darussalam."[214]

India reported the greatest improvement in its mental health legislation. Though the WHO report does not specify what act or statute India changed, reports from the same time period indicate that India reconceptualized their entire mental health scheme in early 2017.[215] The Act specifically states that the country is revising its mental health laws to "align and harmonize" with the CRPD.[216] The law contains many sections and encourages autonomy to the extent possible, prohibits discrimination, establishes rights to access to mental health care and treatment including free care to those who are poor or homeless, among a myriad of other important protections.[217] The original Mental Healthcare Act in India was passed in 1987; the 2017 act, which has been described as a "complete overhaul" of the 1987 regu-

213. *Convention on the Rights of Persons with Disabilities*, UNITED NATIONS TREATY COLLECTION, https://treaties.un.org/pages/ViewDetails.aspx?src=IND&mtdsg_no=IV-15&chapter=4&clang=_en (Mar. 4, 2022) [hereinafter CRPD Post-Treaty].

214. *Id.*

215. Abhisek Mishra & Abhiruchi Galhotra, *Mental Healthcare Act of 2017: Need to Wait and Watch*, 8 INT'L J. APPL. & BASIC MED. RES. 67, 67 (2018).

216. The Mental Healthcare Act, 2017, § 1 (India).

217. *See generally id.*

lation[218] marks an important and dramatic change to India's approach to mental health through the law.

The law was implemented in 2018, so it is logical that India's health metrics have not yet changed. Since the law is so new, very little has been written about its success. Psychiatrists generally approve of the law, though they have expressed some concerns that the law may increase stigmatization of mental health.[219]

While a few correlations were notable, overall, the states which reported an improvement in law did not experience significant related changes in health, likely because of the short timeframe between the two reporting years. Because law is formalistic and does not always describe a state's action plan (which is more typical of policy), legal changes are likely to take more time to have a strong effect on health outcomes. There were, however, a few interesting observations.

The magnitude of the law's increased compliance with human rights instruments was positively associated with either not being a party to the ICESCR or having a relevant reservation to the ICESCR ($r = 0.66$). This may indicate that states that do not want to agree to uphold *all* human rights (and therefore chose not to sign, ratify, accede, or otherwise become a party to the treaty) are nonetheless cognizant of the importance of mental health.

The magnitude of the change in policy was inversely associated with CEDAW signatory status ($r = -0.55$), indicating that those who reported decreases in the policy's adherence to human rights instruments were *more* likely to be parties to CEDAW. While this may seem counterintuitive, states which are parties to CEDAW may be more likely to revisit mental health policies and assess them considering changing understandings of both women's rights and mental health, and are therefore *reporting* a decrease, even if the policy itself was unchanged. For example, Colombia reported that its law's adherence to human rights instruments, last updated in 2013, improved by two points. It also reported that its policy's adherence decreased by three points between the two reporting years, even though it reported that its policy was last updated in 1998. Given that the state has not changed its policy since 1998, something else must account for the difference in policy scoring between the two years. The data demon-

218. Richard M. Duffy et al., *New legislation, New Frontiers: Indian Psychiatrists' Perspective of the Mental Healthcare Act 2017 Prior to Implementation*, 60 INDIAN J. PSYCHIATRY 351, 351 (2018), http://www.indianjpsychiatry.org/text.asp?2018/60/3/351/243392.

219. *Id.*

strates that it is possible for states like Colombia, which are parties to CEDAW, to analyze their policies more critically through a human rights lens than states that are not parties to CEDAW.

B. States That Reported an Improvement in Policy

In this sub-group, only states which reported an improvement in the policy's adherence to human rights between the baseline year and 2017 were analyzed. Twenty-eight countries reported an improvement in their policy: Afghanistan, Bahrain, Burkina Faso, Burundi, Cambodia, Cook Islands, Costa Rica, Czech Republic, Ghana, Iraq, Jamaica, Madagascar, Morocco, Mozambique, Nepal, Oman, Peru, Philippines, Romania, Saudi Arabia, Slovenia, Solomon Islands, Sudan, Sweden, Syrian Arab Republic, Togo, Tonga, and Uruguay. While it may initially be surprising that more countries improved their policy than their law, recall that the WHO views policy as somewhat of a precursor to law—something that expands outside of law and guides the implementation of law.[220] Of these twenty-eight countries, five improved their laws, eleven reported no change, three decreased, and nine did not report a score for their law in one or both years.

Like the law indicator, these countries span nearly the full range of DALYs. The suicide rate decreased in eleven countries. In fourteen countries the suicide rate increased. However, this subgroup is the only group that experienced an aggregate decline in suicide rate. The remaining three countries did not report a suicide rate in at least one year. While it is somewhat alarming that an improvement in policy has overlapped in a rise in suicide rate, the two may not be related. Simply *having* a policy that adheres to international instruments on human rights does not indicate implementation of that instrument. Since policy is big-picture view of an approach to mental health and these countries are reporting an improvement in their policy, it may be that the changes to the policy have not yet been implemented and therefore the mental health burden has not had the opportunity to decrease.

The workforce capacity in these countries ranged from almost no change to dramatic increases and decreases. Oman, for instance, decreased by 10.28 workers per 100,000 people, which is a relatively significant decrease over so few years, particularly in light of the country's reported policy improvement. It is possible, however, that

220. *See infra* Section II.

Oman has improved its policy in response to a declining workforce and a perceived need to improve mental health within its borders. In this "chicken and egg" situation, it may be that Oman, and other similarly situated countries, improved its policy *because* of the declining workforce, rather than the workforce declining because of the policy change.

Interestingly, two of these countries ratified a treaty, the CRPD, in or after 2013; Burundi and Iraq.[221] These countries may have modified their policies as a result of the Plan rather than any treaty. Certainly, countries may have improved their policies out of a perceived need to improve their mental health policy and nothing more, but given the longstanding lack of global attention given to mental health and a recent heavy push from the WHO to encourage greater policy adherence to international human rights instruments, it is likely that countries have improved their policies as a result of the Plan.

Burkina Faso, Nepal, Oman, and Togo reported the greatest improvements in their policies. No information is publicly available, however, about the contents of the countries' mental health policies.

The associations found within the states that improved their policies are more straightforward than those found in the law change subgroup, likely because policy is a more responsive tool to impact health than law. However, similar to the law sub-group, the change in suicide rate was moderately correlated with the change in policy measure ($r = 0.63$), indicating that greater improvements in policy were associated with the largest increases in suicide rate. It is entirely possible however, that states have modified policies to respond to rising rates of suicide.

Importantly, change in policy was moderately correlated with both change in treatment capacity ($r = 0.65$) and change in workforce ($r = 0.69$). These results indicate that countries may be focusing improvements on meeting a capacity need by bolstering the workforce and the improving the ability of the country to meet its mental health disease burden.

The data revealed two strong correlations in this sub-group: change in law and change in workforce ($r = 0.90$) and change in law and change in treatment capacity ($r = 0.85$). The data therefore indicates that of countries that reported improvement in mental health policy, strong associations were seen between the improvement of law

221. *See* CRPD Post-Treaty, *supra* note 213.

self-report and the country's ability to meet its citizens' mental health needs. This suggests that when mental health policy improves in a country, the impact of law may be greater on ensuring the country has the capacity to address mental health than in the absence of policy improvement.

C. States That Reported Decreases in Law

Twelve countries decreased their self-report of how well their law adheres to international human rights instruments.[222] While the countries' honesty is laudable, the question remains: have the countries more honestly assessed their law's adherence to international instruments, or have these countries actively changed the law to make it less in compliance?

It appears the answer may be both. Uruguay and Thailand, for instance, have not changed their law since the baseline, indicating the decrease in report may be a more honest look at the law or a difference in interpretation of the law by the responder in each year, particularly because Uruguay has not changed its law since 1936. Austria, China, Iraq, Mexico, and the Republic of Korea, however, each changed their law in 2013 or later, giving some credence to the idea that these countries may have modified their law and become less in compliance with international instruments. To complicate things further, of these twelve, seven reported no change in their policy, but Iraq, Solomon Islands, and Uruguay reported improvements in policy while Albania and Mexico reported decreases in policy.

Though it would be logical to assume that states who report a decrease in legal compliance with international instruments may simply not have agreed to those instruments in the first place, the data disagrees. All twelve countries consider themselves bound by the ICESCR, CEDAW, and the Convention of the Rights of the Child with only one relevant reservation.[223] Eleven consider themselves bound by the CAT and CRPD with only one country having a relevant reservation to each.[224] Ten countries are bound by the ICCPR

222. Albania, Austria, Chile, China, Iraq, Mexico, New Zealand, Republic of Korea, Solomon Islands, Spain, Thailand, and Uruguay.

223. The Republic of Korea has a relevant reservation to the CRPD (relating to life insurance). CRPD Post-Treaty, *supra* note 213.

224. The Solomon Islands signed, but never ratified CRPD. *See Solomons Sign UN Convention on Disabilities*, SOLOMON TIMES (Sept. 26, 2008, 2:43 PM), https://www.solomontimes.com/news/solomons-sign-un-convention-on-disabilities/2693. New Zealand has a relevant reservation to CEDAW (relating to Chief titles in the Cook Islands and views on inferiority of women). *See*

with no relevant reservations.[225] Two countries ratified a treaty, the CRPD, after the baseline year.[226] Therefore, it is illogical to think the decrease in law compliance originates from *not* intending to uphold human rights less than any other category of country.

The correlations revealed in states who reported a decrease reveal an interesting relationship. While the change in suicide and change in treatment capacity are strongly *positively* correlated (r = 0.75), the change in suicide and change in workforce are strongly *negatively* correlated (r = -0.78). Since, overall, the change in treatment capacity and change in workforce variables are strongly correlated with each other, this is a surprising result.[227] While the absolute value of these correlations is similar, indicating the strength of the relationship in the two correlations is approximately equally strong, the direction of the correlations is opposite from one another.

The data indicates that the change in suicide rate and the change in treatment capacity move in the *same* direction; that is, countries in which the change in suicide between the two years increased also experienced an increase in the change in treatment capacity, and countries in which the change in suicide rate has decreased also experienced a decrease in the change in treatment capacity. Conversely, the data revealed that the change in suicide rate and the change in workforce move in *opposite* directions; countries in which the change in suicide rate has increased experienced a *decrease* in the change in workforce capacity, and countries in which the change in suicide rate has decreased experienced an *increase* in the change in workforce capacity.

These results might indicate that these particular countries are in a transitional period. As the suicide rate is increasing, a country may be recognizing the need for increased treatment and trying to build up the workforce to address mental health. However, these countries

Convention on the Elimination of All Forms of Discrimination Against Women, UNITED NATIONS TREATY COLLECTION, https://treaties.un.org/pages/ViewDetails.aspx?src=IND&mtdsg_no=IV-8&chapter=4&clang=_en (last visited Mar. 4, 2022) [hereinafter CEDAW Post-Treaty]. Importantly, however, Thailand objects to the definition of torture, and the definition itself is the provision that relates most closely to mental health. *Id.*

225. China signed, but never ratified the ICCPR. International Covenant on Civil and Political Rights, Dec. 19, 1966, 999 U.N.T.S. 171, 172, 260.

226. Iraq and Albania. *See* CRPD Post-Treaty, *supra* note 213.

227. When two variables are strongly correlated with one another, each variable's correlation with a third variable is expected to be similar. If variable A and variable B are strongly correlated (for example, r = 0.95), the expectation is that the correlation between variables A and C, and variables B and C would be similar (for example, A and C correlation could be r = 0.23, and B and C correlation could be r = 0.27).

may not yet be at a point where the treatment availability is sufficient to meet the in-country need. Importantly, very few countries whose law decreased in compliance with international human rights instruments reported on these measures, so the sample is quite small and therefore not necessarily reflective of a true trend.

D. States That Reported Decreases in Policy

Twenty-one states reported decreases in policy score between the two years.[228] Interestingly, all but five of these states reported revising their policy in 2013 or later, indicating—in contrast to states that reported changes in law score—these countries may have changed their policy in such a way that it comes into less compliance with international human rights instruments.

The treaty status of the countries which reported a decline in the policy roughly mirrors that of the decline in law. All twenty-one countries are bound by the CRC and all but one country is bound by CEDAW.[229] Nineteen countries are bound by the ICCPR and ICESCR,[230] and eighteen countries are bound by the CRPD[231] and the CAT.[232] Generally speaking, the six treaties are binding on between eighty-six and one hundred per cent of the countries who reported their policy in lesser compliance with international human rights instruments.

Four countries ratified the CRPD after the baseline report: Albania, Iceland, Micronesia, and Sao Tome and Principe. Additionally,

228. Albania, Armenia, Bhutan, Bosnia and Herzegovina, Colombia, Denmark, El Salvador, Finland, Iceland, Iran, Jordan, Lebanon, Mexico, The Federated States of Micronesia, Pakistan, Paraguay, Poland, Qatar, Sao Tome and Principe, Timor-Leste, and Yemen.

229. Iran is not a party to CEDAW. CEDAW Post-Treaty, *supra* note 224.

230. Bhutan and the Federated States of Micronesia are not parties to the ICCPR or the ICESCR. *International Covenant on Economic, Social and Cultural Rights*, UNITED NATIONS TREATY COLLECTION, https://treaties.un.org/Pages/ViewDetails.aspx?src=IND&mtdsg_no=IV-3&chapter=4 (last visited Mar. 6, 2022) [hereinafter ICESCR Post-Treaty]; *International Covenant on Civil and Political Rights*, UNITED NATIONS TREATY COLLECTION, https://treaties.un.org/Pages/ViewDetails.aspx?chapter=4&clang=_en&mtdsg_no=IV-4&src=IND (last visited Mar. 3, 2022) [hereinafter ICCPR Post-Treaty].

231. Bhutan and Lebanon signed, but did not ratify the CRPD. *See* CRPD Post-Treaty, *supra* note 213. Timor-Leste has not signed, acceded, or otherwise joined the CRPD. *Id.* Iran has a relevant reservation, which states ". . . with regard to Article 46, the Islamic Republic of Iran declares that it does not consider itself bound by any provisions of the Convention, which may be incompatible with its applicable rules." *Id.*

232. Bhutan, Iran, and the Federated States of Micronesia are not parties to the Convention Against Torture. *Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, UNITED NATIONS TREATY COLLECTION, https://treaties.un.org/pages/ViewDetails.aspx?src=IND&mtdsg_no=IV-9&chapter=4&clang=_en (last visited Mar. 6, 2022) [hereinafter CAT Post-Treaty].

two countries ratified the ICCPR: Sao Tome and Principe, and Qatar. Sao Tome and Principe also ratified the CAT after the baseline. It may be that some of the countries' self-reports declined because of an increased recognition of human rights treaties and the role these treaties may play in mental health.

For those states who reported a decrease, the correlations are interesting. The data revealed a moderate correlation between the change in law measure and the change in workforce ($r = 0.67$) and the change in treatment capacity ($r = 0.68$). This metric is interesting, in part, because the changes in law for the same states were positive, negative, and unchanged, suggesting a persistent relationship between law and a country's ability to treat mental health.

There were two correlations related to treaties. The change in law measure was positively associated with CEDAW signatory status ($r = 0.63$), suggesting that states which reported improved law scores were more likely to be signatories to CEDAW than states which did not report improvements, or which reported lower law scores. CRPD ratification year was positively associated with a change in treatment capacity in this group as well ($r = 0.69$). This means that ratification years closer to the present day were associated with larger improvements in treatment capacity. While these relationships are logical, it does beg the question of the role of a *decrease* in policy self-report. It may be that these countries are becoming more aware of mental health as a human right and related implications, and as such are more critical of their internal policies than in previous years. It may also imply that treaties are having a positive effect on health outcomes even in the absence of favorable policy changes. However, as correlation does not imply causation, this is merely conjecture and is not borne out in the data.

E. States That Reported No Change in Law

In this sub-group, only countries which reported no change in the law's adherence to human rights between the baseline year and 2017 were analyzed. Sixty-three countries reported no change in the law between the two years, making this the largest law subgroup. The size of the group is not surprising, since not all laws necessarily need modifying, and maintaining the status quo is often the simplest option.

Out of all the groups, this one demonstrated the highest numbers of treatment providers and of workforce capacity, perhaps indicating

that laws were not changed because they did not need to be changed. Forty-one countries self-rated a five in both years, constituting two thirds of the group. An additional thirteen self-rated a four, counting for one fifth of the group. Of the remaining scores (self-rate of two or three, since no country in the group reported a score of one), half self-rated the country's policy at a four or above. It is plausible that the countries in this group are of the opinion that the countries' compliance with international human rights instruments is presently satisfactory, and therefore changing the law would either be unnecessary or would not be a high priority at this point.

Despite a lack of movement on law changes, these countries were more active than other groups in treaty changes, though perhaps a bit more wary of treaties than other groups as indicated by lower ratification rates and higher rates of reservations. Eleven countries ratified the CRPD after the baseline report.[233] However, seven countries do not consider themselves bound by the CRPD, and an additional five have relevant reservations.[234] Therefore, before 2014, thirty-seven percent of countries in this group did not ascribe, either in whole or in part, to the CRPD as it relates to mental health. Presently, the percent

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233. Barbados, Cote d'Ivoire, Fiji, Georgia, Grenada, Japan, Monaco, Samoa, Suriname, Trinidad and Tobago, and Zimbabwe.

234. Botswana and Macedonia are not parties to the treaty, while Lebanon, Saint Lucia, Tajikistan, Tonga, and the United States have signed but not ratified the CRPD. CRPD Post-Treaty, *supra* note 213.

Egypt's reservation states that:

> The Arab Republic of Egypt declares that its interpretation of article 12 of the International Convention on the Protection and Promotion of the Rights of Persons with Disabilities, which deals with the recognition of persons with disabilities on an equal basis with others before the law, with regard to the concept of legal capacity dealt with in paragraph 2 of the said article, is that persons with disabilities enjoy the capacity to acquire rights and assume legal responsibility ('ahliyyat al-wujub) but not the capacity to perform ('ahliyyat al-'ada'), under Egyptian law.

Id.

Iran states that "Iran declares that it does not consider itself bound by any provisions of the Convention, which may be incompatible with its applicable rules." *Id.*

Israel's reservation states "The State of Israel expresses its reservation with regard to the provisions concerning marriage in Article 23 (1) (a) of the Convention, to the extent that the laws on personal status, which are binding on the various religious communities in Israel, do not conform with these provisions." *Id.*

The relevant portion of Monaco's reservation states that:

> [P]ersons with disabilities have full enjoyment of all human rights and fundamental freedoms on an equal basis with others, but that the Convention does not imply that persons with disabilities should be afforded rights superior to those afforded to persons without disabilities, especially in terms of employment, accommodation and nationality.

Id.

Lastly, Malaysia states that "The Government of Malaysia ratifies the said Convention subject to the reservation that it does not consider itself bound by articles 15 and 18 of the said Convention." *Id.*

has been cut in half, indicating a potentially greater acknowledgement of the role of human rights in mental health.

Regarding the ICESCR, nine countries do not consider themselves bound by the treaty,[235] with an additional country holding a relevant reservation.[236] Notably, however, one country ratified the ICESCR after the baseline report.[237] The signatories and parties to the ICCPR roughly match those of the ICESCR; five countries are not bound by the treaty,[238] three countries hold relevant reservations, and one country ratified after the baseline report. The CAT was the least popular international instrument of all. Twelve countries are not bound by the Convention,[239] with an additional three holding relevant reservations.[240] However, three countries ratified the Convention since the baseline. Three countries have joined the Convention since the baseline report.[241] The CEDAW and the CRC present higher sig-

235. Botswana, Malaysia, Saint Lucia, Samoa, Saudi Arabia, Macedonia, Tonga, and Vanuatu are not parties to the treaty. ICESCR Post-Treaty, *supra* note 230. Additionally, the United States of America signed but did not ratify the ICESCR. *Id.*

236. Egypt's reservation states that it understands the treaty not to be in conflict with the laws of Islam. *Id.*

237. Fiji ratified the treaty in 2018. *Id.*

238. Macedonia, Malaysia, Saudi Arabia, and Tonga are not parties to the ICCPR. ICCPR Post-Treaty, *supra* note 230. Saint Lucia signed the ICCPR, but has not ratified it. *Id.* Fiji joined the ICCPR in 2018. *Id.* Egypt's reservation acknowledges the treaty to the extent it is compatible with Islam. *Id.*; *see also* ICESCR Post-Treaty, supra note 230.

Israel's reservation states:

> With reference to Article 23 of the Covenant, and any other provision thereof to which the present reservation may be relevant, matters of personal status are governed in Israel by the religious law of the parties concerned. To the extent that such law is inconsistent with its obligations under the Covenant, Israel reserves the right to apply that law.

ICCPR Post-Treaty, *supra* note 230.

The United States' reservation allows for distinctions to be made so long as they are "at minimum, rationally related to a legitimate governmental objective." *Id.*

239. Barbados, Iran, Jamaica, Macedonia, Malaysia, Saint Lucia, Suriname, Tonga, Trinidad and Tobago, Tanzania, and Zimbabwe are not parties to the Convention and Sudan signed but did not ratify the Convention. CAT Post-Treaty, *supra* note 232.

240. Fiji and the United States of America hold reservations. *Id.* Fiji's reservation states:

> The Government of the Republic of Fiji recognizes the article 14 of the Convention only to the extent that the law of the Church (Code of Canon Law, 1981) and its catechism (Catechism of the Catholic Church, 1987) enumerate and clearly identify forms of behaviour that can harm the bodily or mental integrity of the individual, condemn their perpetrators and call for the abolition of such acts.

Id.

Amid a lengthy reservation, the United States provides its own definition of torture, holds that the death penalty is allowable and does not constitute torture, and acknowledges the treaty insofar as the "term 'cruel, inhuman or degrading treatment or punishment' means the cruel, unusual and inhuman treatment or punishment prohibited by the Fifth, Eighth, and/or Fourteenth Amendments to the Constitution of the United States." *Id.*

241. Fiji, Grenada, and Samoa. *Id.*

natory rates. Only five countries declined to join CEDAW,[242] but the Convention is accompanied by five broad religion-based reservations.[243] Only two countries[244] are not bound by the CRC, and three additional countries hold reservations.[245]

Perhaps the most important correlation revealed is that the change in suicide rate and year of law's last revision are inversely moderately correlated (r = -0.58). This indicates that the more recently a law was revised, the greater the decrease in the rate of change of suicide. The relationship between change in suicide rate and the year of policy's last revision was similarly correlated (r = -0.60). Since this group of countries did not report changes in the law's compliance with human rights instruments, this data may indicate a better time-delay effect, wherein laws recently changed—but not so recently changed that health indicators have not had time to demonstrate a response—may be impacting rates of suicide in a valuable way. Given that policies are typically modified before laws are changed, the statistical relationship may be reflecting the benefits of a coordinated effort to amend laws and policies to positively impact mental health.

Another correlation of note is that the change in policy was moderately correlated with the change in treatment capacity (r = 0.69). This too may demonstrate the benefits of a longer-scale lookback at law and policy change. The correlation implies that as policy improves, the change in treatment capacity also improves. Since this group has indicated no change in the *law's* compliance with international human rights instruments and therefore acts as a control of sorts, this correlation may speak to the impact policy can have on improving mental health.

242. Iran, Macedonia, Sudan, and Tonga are not parties. CEDAW Post-Treaty, supra note 224. The United States of America signed but did not ratify the CEDAW. *Id.*

243. Algeria, Bangladesh, Morocco, Pakistan, and Saudi Arabia each have broad reservations that, should the Convention conflict with Islamic law, or the country's law which is based on Islamic teachings, the Islamic law will prevail over the Convention. *Id.*

244. Macedonia is not a party to the Convention. *Convention on the Rights of the Child*, UNITED NATIONS TREATY COLLECTION, https://treaties.un.org/pages/ViewDetails.aspx?src=IND&mtdsg_no=IV-11&chapter=4&clang=_en (last visited Mar. 7, 2022) [hereinafter CRC Post-Treaty]. The United States of America has signed, but not ratified the Convention. *Id.*

245. Iran and Saudi Arabia hold reservations which explain in the event of a conflict between the Convention and the laws of Islam, the laws of Islam prevail. *Id.* Malaysia's reservation states that in the case of a conflict between the Convention and Malaysia's law, Malaysia's law will prevail. *Id.*

F. States That Reported No Change in Policy

In this sub-group, only countries which reported no change in the policy's adherence to human rights between the baseline year and 2017 were analyzed. Seventy-three states reported no change in the policy between the two reporting years, making this group the largest sub-group. Since overall, more states reported policy metrics than law metrics, and because all states may not need to change a law or policy or prefer the status quo, it is unsurprising that this is the largest subgroup.

The states which did not report a change in the policy score have the highest suicide rate of the six subgroups. Otherwise, the metrics for this group were consistently in the middle range of the reported metrics.

Two features of this group were surprising: new treaty ratifications and a lack of correlations. Within this group, there were a remarkable number of countries that ratified treaties after the baseline year. Sixteen countries ratified the CRPD in or after 2013.[246] Only three countries in this group are not bound by the CRPD.[247] Five countries detailed reservations to the CRPD.[248] The influx of so many new signatories to the CRPD in recent years may signify an increase in awareness regarding mental health. While the CRPD is not limited to mental health, but instead describes the rights of all disabled persons, it nonetheless interacts significantly with mental health and the recognition of mental health as a human right. It may be that the countries which recently have become bound by the CRPD have not changed their policy *yet* and may have plans to address mental health policy in the near future.

The status of the other treaties was in line with the other groups. The ICESCR is binding on all but ten countries in this group,[249] and

246. Barbados, Central African Republic, Cote d'Ivoire, Fiji, Gambia, Georgia, Grenada, Guyana, Japan, Marshall Islands, Monaco, Samoa, Suriname, Trinidad and Tobago, Vietnam, and Zimbabwe. CRPD Post-Treaty, *supra* note 213.

247. Botswana and the Former Yugoslav Republic of Macedonia are not parties to the CRPD. *Id.* The United States of America signed but did not ratify the CRPD. *Id.*

248. Brunei Darussalam and Israel hold broad reservations on religious grounds. *Id.* Monaco's reservation recognizes the equality of persons with disabilities, but states that persons with disabilities should not "be afforded rights superior to those afforded to persons without disabilities." *Id.* The Republic of Korea hold a reservation regarding life insurance. *Id.* Malaysia considers itself not bound by articles 15 and 18 of the Convention. *Id.*

249. Botswana, Brunei Darussalam, Malaysia, Micronesia, Mozambique, Samoa, Former Yugoslav Republic of Macedonia, United Arab Emirates, and Vanuatu are not parties. ICESCR Post-Treaty, *supra* note 230. The United States of America has signed but not ratified the ICESCR. *Id.*

one additional country holds a relevant reservation.[250] An additional five countries joined after 2013.[251] The ICCPR is binding on all but six countries in this group,[252] with two relevant reservations[253] and two countries joining after the baseline report.[254] The CAT saw seven new members after the baseline reporting year.[255] The Convention is binding on all but nine states.[256] Four countries hold reservations to the Convention.[257] Both CEDAW and the CRC are widely adopted in this subgroup. All but two countries are bound by CEDAW and the CRC.[258] Three countries—though not the same three—hold relevant reservations against the two Conventions.[259] No country has joined either treaty since the baseline year.

There were no moderate or strong correlations between any measure in this subgroup. While this finding was initially surprising, it logically follows the trends detailed in other subgroups. Since policy is typically the precursor to all other changes affecting mental health, in the absence of *any* movement on policy, other measures are likely not expected to have a significant relationship to one another. In contrast

250. *Id.*

251. Belize, Fiji, Marshall Islands, Myanmar, South Africa. *Id.*

252. Brunei Darussalam, Malaysia, Myanmar, Former Yugoslav Republic of Macedonia, and the United Arab Emirates are not parties to the treaty. ICCPR Post-Treaty, *supra* note 230. China has signed but not ratified the treaty. *Id.*

253. Israel's reservation states that in the case of a conflict of religious law and the treaty, Israel may apply the religious law. *Id.* The United States hold that distinctions based on protected categories are allowable when "rationally related to a governmental objective." *Id.*

254. Fiji and the Marshall Islands. *Id.*

255. Central African Republic, Fiji, Gambia, Grenada, Marshall Islands, Samoa, and Vietnam. CAT Post-Treaty, *supra* note 232.

256. Barbados, Malaysia, Myanmar, Suriname, the Former Yugoslav Republic of Macedonia, Trinidad and Tobago, and Zimbabwe are not parties to the Convention. *Id.* Additionally, Brunei Darussalam and India have signed but not ratified the Convention. *Id.*

257. Fiji and Thailand object to the definition of Torture and find it "applicable to the extent as expressed in the [country's law]." *Id.* However, the Thai reservation states that the King shall revise the law to be more in line with the Treaty terms. *Id.* The United Arab Emirates states that lawful sanctions or pain and suffering "incidental to these lawful sanctions" does not constitute torture. *Id.* The United States of America reserves that the definition of torture does not expand past conduct "prohibited by the Fifth, Eighth, and/or Fourteenth Amendments to the Constitution of the United States." *Id.*

258. The Former Yugoslav Republic of North Macedonia is not a party to CEDAW or the Convention on the Rights of the Child. CEDAW Post-Treaty, *supra* note 224; CRC Post-Treaty, *supra* note 244. The United States of America has signed both, but not ratified either Convention. CEDAW Post-Treaty, *supra* note 224; CRC Post-Treaty, *supra* note 244.

259. Algeria and Bangladesh hold broad reservations on religious grounds to CEDAW, while Brunei Darussalam and the United Arab Emirates hold religious or cultural reservations to the Convention for the Rights of the Child. CEDAW Post-Treaty, *supra* note 224; CRC Post-Treaty, *supra* note 244. New Zealand reserves that traditional customs for inheritance of certain titles may prevail over the treaty. CEDAW Post-Treaty, *supra* note 224. Malaysia reserves that its own law should prevail over the treaty in case of conflict. *Id.*

to the relationships demonstrated in the subgroup in which no change in law was reported, there is no known or suspected precursor to policy change.

VII. CONCLUSIONS

The WHO's goal for 80% of countries to have a policy for mental health and 50% of countries to have a law for mental health in line with international human rights instruments presents challenges in assessing progress towards that goal since the WHO has not stated what score a country must receive to be considered successful in this metric.

While the exact progress towards the goal is unknown, it is notable that more countries have improved their law and policy than have decreased compliance with international instruments, though countries which reported no change represent the largest group. In aggregate, countries are experiencing a decrease in mental health burden and an increase in capacity to address mental health. Specific successes in countries like India are indicators that global progress in mental health is likely on the horizon.

Though not conclusive, the relationships uncovered throughout these six subgroups support a theory that policy change drives future changes in mental health law, which in turn supports structural mechanisms, such as improved access to mental health care or changes in social level factors such as housing that can impact mental health within a state. Since this study does not assess causality, one important possibility is that countries may be reading their own laws differently, a theory which deserves future research.

While this study accounts for only a short time span, looking at discrete changes over a small course of time can help identify an "order of operations" of sorts. From this data, no relationship was demonstrated with any variables in the group which reported no policy change. By contrast, the group that did not report any changes in law, regardless of whether or not changes in policy were reported, demonstrated strides in increasing workforce capacity and decreasing suicide rate.

Throughout the groups, more concrete relationships were demonstrated in policy groups than law groups. In part, this may be due to different cultural conceptions of law, and how countries define law versus policy. Additionally, it further supports the notion that policy is an important component of mental health reform.

An important limitation of this study is that it does not assess causation, and the variables are not sensitive to cultural variation—whether in regard to conceptualizations of law, enforcement of law or policy, or even the fundamental concept of mental health. While assessing relationships between suicide and policy change is an important step in addressing and upholding mental health as a human right, it is a myopic view of mental health. Though a difficult task, the WHO and other international entities addressing mental health as a human right should strive to create a culturally humble approach to monitoring, evaluating, and improving the status of mental health within a country.

The WHO is now tasked with a challenging question: what next? Now that the 2013–2020 Plan has ended, the WHO must reevaluate the barriers to improving mental health—particularly in terms of human rights. If countries have agreed to international human rights instruments with no reservations yet are actively decreasing their adherence to those instruments as it relates to mental health, the WHO must work to spur change through other means.

As countries like India implement their plans, the WHO can learn from field successes and failures to help assess what tools, strategies, and assistance countries will need to move forward with mental health as a human right in a meaningful way. Longer-term analyses will also benefit the WHO to help determine the time-delay from policy and law creation to changes in health outcomes. By readying expectations and creating culturally relevant interventions, the WHO can work with countries to evolve and improve how countries recognize and address mental health as a human right.

Taking Food from the Mouths of Babes: WIC's Punitive Treatment of Low-Income Mothers who Won't or Can't Breastfeed

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I. INTRODUCTION

> When I went to my first WIC appointment, I was breastfeeding and all was well. The next time I told them that my milk was drying up and I needed to use formula, it felt like I had to BEG them to put my baby on the formula program. I kinda felt like a criminal for asking. You would think I wanted to feed my baby poison or something.
>
> –WIC Participant[3]

The United States Department of Agriculture (USDA) Special Supplemental Nutrition Program for Women, Infants, and Children Program (WIC) is a critically important part of the effort to provide nutritional support to low-income pregnant, breastfeeding, and non-breastfeeding postpartum women[4] and to infants and children up to age five who are found to be at nutritional risk in the United States.[5] Half of all infants in the United States receive nutritional assistance under the program.[6] While recent data is unavailable, unemployment resulting from the Covid 19 epidemic beginning in March 2020 has only increased the importance of the program in providing support to the nation's low-income families.[7]

3. COURTNEY JUNG, ACTIVISM: HOW FEMINISTS AND FUNDAMENTALISTS, HIPPIES AND YUPPIES, AND PHYSICIANS AND POLITICIANS MADE BREASTFEED, BIG BUSINESS AND BAD POLICY 114 (2015).

4. This article will generally use the terms "women," "mother," and "breastfeeding," to be consistent with the language used in the WIC program documents and outreach materials. The author recognizes that every person who feeds their child with human milk does not identify as female, and that transmen face exceptional barriers to chestfeeding. *See* Britni De La Cretaz, *What It's like to Chestfeed*, THE ATLANTIC (Aug. 23, 2016).

5. *About WIC - WIC at a Glance*, U.S. DEP'T OF AGRIC.: FOOD AND NUTRITION SERV., (Oct. 10, 2013), https://www.fns.usda.gov/wic/about-wic-glance.

6. CAROLINE DUNN, ERICA KENNEY, SARA BLEICH & SHEILA FLEISCHHACKER, ROBERT WOOD JOHNSON FOUND., HEALTHY EATING RESEARCH, STRENGTHEN WIC'S IMPACT DURING AND AFTER THE COVID-19 PANDEMIC, RESEARCH BRIEF (July 2020), https://healthyeatingresearch.org/wp-content/uploads/2020/07/HER-WIC-Brief-072220_final.pdf.

7. *Id*.

In an effort to increase breastfeeding among women who participate in WIC (which is substantially lower than the general population), the program has implemented a number of initiatives. One of these initiatives is a financial incentive.[8] A WIC regulation requires that women who do not breastfeed receive less food for both themselves and their babies.[9] This was promoted as a way to incentivize breastfeeding, in part because breastfeeding is presumed to have substantial health benefits to both babies and their mothers.[10] The actual science in support of this assertion is not very strong.[11] Even if the evidence was strong, this paper argues that this regulation actually has a punitive impact on the nation's most vulnerable women and families, and should be abolished.

Part two of this paper examines the issue of breastfeeding and its implications for Reproductive Justice. It also interrogates the presumption underlying the WIC regulation: that breastfeeding yields substantially superior health outcomes for infants and children when compared to formula feeding. Part three provides a brief history of recommendations on breastfeeding, and an analysis of accompanying policy initiatives. Part four reviews the WIC breastfeeding regulation. Part five advocates for individualized assessments that consider the circumstances of each family and removing the financial penalty for those who cannot or will not breastfeed. As it stands, the penalty for using formula in WIC results in reproductive oppression of WIC participants; removing the formula penalty in WIC advances Reproductive Justice.

II. THE DECISION TO BREASTFEED AS A MATTER OF REPRODUCTIVE JUSTICE

A. What is Reproductive Justice?

The theory of Reproductive Justice was developed in 1994 by Black women activists who gathered to discuss President Clinton's (failed) health reform efforts and the marginalization of reproductive health care.[12] Motivated by the 1994 International Conference on

8. *See infra* Section IV.B. on cost differential to feed infants for those who do and do not breastfeed.

9. *Id.*

10. *See infra* Section II.C.

11. *See infra* Section II.C.1.

12. Loretta J. Ross & Rickie Solinger, Reproductive Justice: An Introduction 63–64 (2017).

Population and Development held in Cairo, Egypt, these activists recognized that international discussions around reproduction were rooted in human rights.[13] This meant that policies impacting reproduction were made in consideration of the full spectrum of social and economic issues. Human rights framing made it impossible to separate reproductive decision-making from other social justice issues, including poverty, immigration, disability rights, education, healthcare, and housing.[14] Furthermore, it was apparent to those activists that the more common framing of Reproductive Rights, which is primarily focused on the right to not have children through access to contraception and abortion, failed to address the persistent attacks on childbearing experienced by those who were not white, financially secure, and able-bodied.[15]

Reproductive Justice requires that every person have the resources and education, and feel safe to have children, to not have children, and to raise children in an environment where their potential can flourish.[16] At the micro level, it requires, for example, the right to make childbearing and childrearing decisions free from interpersonal violence or coercion. At the macro level, it requires the dismantling of systems that entrench generational poverty and inequality. While the latter aspiration is clearly one for the long-term, a critical component that moves us closer to this goal is challenging governments to provide the necessary resources for individuals to effectuate their own vision of family.[17]

B. Breastfeeding Decisions and Reproductive Justice

Feeding decisions are an important part of parents' child-rearing responsibilities. Parents' ability to make informed choices around the

13. *What is Reproductive Justice?*, SISTER SONG, https://www.sistersong.net/reproductive-justice (last visited Feb. 2, 2022).

14. *See* ROSS & SOLINGER, *supra* note 12, at 82–85.

15. *Id.* at 93–96.

16. *Id.* at 65. Reproductive Justice also supports the right to sexual autonomy, recognizing that reproductive oppression is often an effort to control "undesirable" sexual expression, especially by women and other marginalized groups. *Id.*

17. This is a key factor that distinguishes Reproductive Justice from Reproductive Rights. Reproductive Justice asserts a positive right to government assistance to effectuate one's choices. Reproductive Rights is premised on negative rights, exemplified by the right to privacy as expressed in *Roe v. Wade*. *See id.* at 10. For a comprehensive treatment of the differences between Reproductive Rights, Reproductive Health and Reproductive Justice, *see* A NEW VISION FOR ADVANCING OUR MOVEMENT FOR REPRODUCTIVE HEALTH, REPRODUCTIVE RIGHTS AND REPRODUCTIVE JUSTICE, ASIAN CMTYS. FOR REPROD. JUST. 1 (2005) https://forwardtogether.org/wp-content/uploads/2017/12/ACRJ-A-New-Vision.pdf (currently named Forward Together).

feeding of their children and receiving the necessary support to carry out those choices is therefore a critical component of Reproductive Justice. There have been a few public controversies around particular diets for children,[18] or children whose weight is alleged to endanger their health,[19] but none comes close to the public debates around breastfeeding.

The ability to breastfeed intersects with a myriad of social justice issues. A woman who works a retail job without paid leave, a set schedule, a private room, adequate breaks and a refrigerator would find it extremely difficult to breastfeed. Those with high quality healthcare may receive more professional assistance to breastfeed in the difficult early days following birth. Someone without the luxury of a multi-room home may not have the needed privacy to breastfeed, especially if cultural or social customs require the mother to be in a room without boys or men.

In analyzing breastfeeding as a Reproductive Justice issue, one would simply ask: does every individual have both the right to, and the right not to breastfeed, and are they given the social, financial, and other support needed to effectuate their decision? At this time, a comprehensive analysis of breastfeeding as a matter of Reproductive Justice has not been published, but scholars have analyzed the barriers,[20] including barriers specific to certain populations.[21] Others have explored particular aspects of breastfeeding,[22] breastfeeding and employment,[23] and the impact of the Affordable Care Act's breastfeeding provisions.[24] Additionally, a recent book documents the many

18. Brittany Bacon, *Custody Battle Boils Over Vegan Diet*, ABC NEWS (Jan. 8, 2009, 12:18 AM), https://abcnews.go.com/TheLaw/story?id=3323914&page=1.

19. Ashby Jones & Shirley S. Wang, *Obesity Fuels Custody Fights: Ex-Spouses Hurl Accusations in Court About Their Kids' Nutrition and Exercise*, WALL ST. J. (Oct. 29, 2011), https://www.wsj.com/articles/SB10001424052970204294504576613100908629810.

20. *See* Megan Unger, *Barriers to Fully Informed Decisions on Whether to Breastfeed or Formula Feed in the United States*, 31 HASTINGS WOMEN'S L.J. 183 (2020).

21. *See, e.g.*, Ashley McLaughlin Leen, *U.S. Prisons' Lactose Intolerance: Lactation and Incarcerated Women's Eighth Amendment Right to Breast Pumps*, 45 N.Y.U. REV. L. & SOC. CHANGE 1, 3, 5 (2021).

22. *See, e.g.*, Mathilde Cohen, *The Right to Express Milk*, 33 YALE J. L. & FEMINISM 47, 49 (2021).

23. *See, e.g.*, Madeleine Gyory, *Medical Condition or Childcare Choice? Breastfeeding and Lactation Discrimination After Young v. UPS*, 43 N.Y.U. REV. L. & SOC. CHANGE 475 (2019).

24. *See, e.g.*, Nancy Ehrenreich & Jamie Siebrese, *Breastfeeding on a Nickel and a Dime: Why the Affordable Care Act's Nursing Mothers Amendment Won't Help Low-Wage Workers*, 20 MICH. J. RACE & L. 65, 67, 70 (2014).

ways that Black women are not adequately supported, and sometimes actively discouraged, from breastfeeding.[25]

The issue of pregnancy and substance use has often been the subject of Reproductive Justice analysis.[26] The same judgment, shaming, and lack of consideration of a woman's individual circumstances is also seen in the treatment of breastfeeding.[27] Likewise, the two issues share some indicators that reproductive oppression is taking place: matters that are best addressed through public health channels end up in the criminal legal system; focus is placed on the recalcitrant individual – "the bad mother" – rather than the systemic issues that contribute to the problem; and heightened scrutiny is applied to the behaviors of low-income mothers and Women of Color. As with substance use by pregnant women, breastfeeding has been at the center of child welfare cases,[28] custody disputes,[29] and even prosecutions for homicide.[30]

Another way to identify whether reproductive oppression (or coercion) is taking place is to see if there is "incentivization" of particular choices through the provision or withholding of government support. The most obvious example is abortion. The Hyde Amendment denies funding for abortions to women who receive Medicaid, except under a narrow set of circumstances.[31] Rep. Henry Hyde made

25. ANDREA FREEMAN, SKIMMED: BREASTFEEDING, RACE AND INJUSTICE 2–3, 10–11, 13 (2020). Freeman centers her analysis around a 1946 marketing campaign by Pet Milk featuring Black quadruplets. *Id.*

26. MICHELE GOODWIN, POLICING THE WOMB: INVISIBLE WOMEN AND THE CRIMINALIZATION OF MOTHERHOOD 4–6 (2020); Julie B. Ehrlich, *Breaking the Law by Giving Birth: The War on Drugs, the War on Reproductive Rights, and the War on Women*, 32 N.Y.U. REV. L. & SOC. CHANGE 381, 382 (2008).

27. Hanna Rosin, *The Case Against Breast-Feeding*, THE ATLANTIC (Apr. 2009), https://www.theatlantic.com/magazine/archive/2009/04/the-case-against-breast-feeding/307311/.

28. Jesse Mendoza & Jay Handelman, '*American Idol*' *Star Syesha Mercado Fights for Son's Custody Over Claims of Malnutrition*, SARASOTA HERALD-TRIB. (May 18, 2021, 3:25 PM), https://www.heraldtribune.com/story/news/local/sarasota/2021/05/18/american-idol-star-syesha-mercado-fights-custody-her-son-allegations-malnutrition/5091050001/. Mercado went to the hospital seeking assistance with feeding after her breastmilk supply started drying up, and her son would not take in any other liquids. *Id.* Child Protective Services took custody of Mercado's child and placed him in foster care, claiming he was malnourished. *Id.*

29. Emily Strohm, *Nicole Curtis Defends Her Decision to Breastfeed 30-Month-Old Son Amid Vicious Custody Battle*, PEOPLE (Nov. 8, 2017, 8:00 AM), https://people.com/tv/nicole-curtis-breastfeed-30-month-old-son-custody-battle/.

30. Cheeks v. N.Y., 998 N.Y.S.2d 847, 848, 851–54, 878 (N.Y. App. Div., Dec. 16, 2014) (involving a woman awarded $2 million for wrongful prosecution; she was charged with homicide for negligently breastfeeding her daughter); Nina Bernstein, *Bronx Woman Convicted in Starving of Her Breast-Fed Son*, N.Y. TIMES (May 20, 1999), https://www.nytimes.com/1999/05/20/nyregion/bronx-woman-convicted-in-starving-of-her-breast-fed-son.html.

31. *See generally* Guttmacher Institute, *The Hyde Amendment: A Discriminatory Ban on Insurance Coverage of Abortion*, GUTTMACHER INST. (May 2021), https://www.guttmacher.org/

no attempt to conceal his desire to limit poor women's choices. "I would certainly like to prevent, if I could legally, anybody having an abortion, a rich woman, a middle-class woman, or a poor woman. Unfortunately, the only vehicle available is the [Medicaid] bill."[32]

The so-called "Family Cap" is another example of attempted state control of low-income women's reproductive decisions.[33] These are state provisions that deny additional cash assistance to low-income families that are already receiving support. Again, the policy is motivated by the belief that denying poor women additional (paltry) sums will result in the desired behavioral change.

Obviously, a new mother has the right not to breastfeed, but it is a choice that comes with consequences, namely shaming. There are endless examples in the popular press of the harsh judgement experienced by women who do not breastfeed (or appear to be formula feeding when using a bottle to feed with breastmilk).[34] One commentator describes breastfeeding as "[t]he ultimate badge of responsible parenting" and explains how this message is amplified by the media and in public health messaging.[35] As explored in this paper, this shaming is furthered by federal efforts to "encourage" breastfeeding among populations where it is lagging behind, along with inaccurate reporting around the scientific findings of its benefits.

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fact-sheet/hyde-amendment. While those who are impregnated by rape or incest, or whose lives are endangered by their pregnancies are legally permitted to receive funding for their abortions, studies indicate that there are few abortions provided under these exceptions. Guttmacher Institute, *Medicaid Coverage of Abortion*, GUTTMACHER INST. (Feb. 2021), https://www.guttmacher.org/evidence-you-can-use/medicaid-coverage-abortion (citing in footnote 16 a study finding that abortion providers only received reimbursement for 58% of the procedures that should have been covered under Hyde); *see also Abortion Funding for Poor Women: The Myth of the Rape Exception*, CTR. FOR AM. PROGRESS (Apr. 28, 2005), https://www.americanprogress.org/article/abortion-funding-for-poor-women-the-myth-of-the-rape-exception/.

32. WHOSE CHOICE? HOW THE HYDE AMENDMENT HARMS POOR WOMEN, CTR. FOR REPROD. RIGHTS (2010), https://reproductiverights.org/sites/crr.civicactions.net/files/documents/Hyde_Report_FINAL_nospreads.pdf (citing 123 CONG. REC. 19,700 (1977) (statement of Rep. Henry Hyde)).

33. For a comprehensive review of these laws and efforts to overturn them, *see* BRINGING FAMILIES OUT OF 'CAP'TIVITY: THE PATH TOWARD ABOLISHING WELFARE FAMILY CAPS, CTR. ON REPROD. RTS. & JUST. 1–2, 9–12, (2016), https://www.law.berkeley.edu/wp-content/uploads/2015/04/2016-Caps_FA2.pdf.

34. Hanna Rosin, *The Case Against Breast-Feeding*, THE ATLANTIC (Apr. 2009), https://www.theatlantic.com/magazine/archive/2009/04/the-case-against-breast-feeding/307311/.

35. *Id.*

C. Breastfeeding Basics: Health Impacts and Decision-making

1. Breastfeeding Benefits for Infants and Children[36]

I include readings on breastfeeding in both classes I teach: Reproductive Justice and The First Thousand Days (focusing on the period from conception to the age of two). I believe it is important for students to have some understanding of the data that drives public health policy. Most are shocked to learn that the data does not show an overwhelming benefit to breastfeeding as compared to formula.[37] The mothers in my class respond with either relief (if they were not able to follow the recommended one year of exclusive breastfeeding) or degrees of anger (if they did, and are only now finding out that the data on its benefits are not so clear cut).[38] Breastfeeding has been associated with a huge range of benefits, from increasing intelligence, reducing common infant infections, preventing chronic conditions like diabetes and asthma, and even sparing babies from sudden infant death syndrome.[39] Despite the public perception that breastfeeding is clearly superior to formula feeding, one researcher notes, "[a] more detailed examination of existing epidemiological studies regarding the effects of breastfeeding on subsequent child health and development reveals more questions than it does answers."[40]

One particularly positive and influential report of breastfeeding's benefits came from the American Academy of Pediatrics (AAP) Policy Statement. AAP endorsed breastfeeding as the gold standard for infant nutrition, and recommended exclusive breastfeeding for six months and continuation for up to one year if feasible.[41] This report drew heavily on a meta-analysis (a study of studies) conducted by the Agency for Healthcare and Research Quality (AHRQ), which was re-

36. There are also potential benefits to breastfeeding for mothers, such as reduced risk of breast cancer and weight management. This is beyond the scope of this article, but the same confounders that are discussed below regarding the benefits for infants are also present for mothers.

37. JUNG, *supra* note 3, at 71–72.

38. This is not to say that my students are any representative sampling of those who breastfeed, but their responses are indicative of inaccurate messages that even highly educated individuals have received about the benefits of breastfeeding.

39. JUNG, *supra* note 3, at 72.

40. Cynthia G. Colen & David M. Ramey, *Is Breast Truly Best? Estimating the Effects of Breastfeeding on Long-term Child Wellbeing in the United States Using Sibling Comparisons*, 109 SOC. SCI. & MED. 55, 56 (2014).

41. *See* Arthur I. Eidelman & Richard J. Schanler, *Breastfeeding and the Use of Human Milk*, 129 PEDIATRICS e827, e827–28 (2012).

porting the benefits of breastfeeding.[42] Although the AAP claimed that breastfeeding reduced the risk of leukemia by 20% and asthma by 40%, the AHRQ reported that research on these correlations were "equivocal."[43] The AAP also claimed that breastfeeding reduced Type 1 Diabetes by 30% and Type 2 Diabetes by 40%, when in fact the AHRQ study concluded that the correlation should be "interpreted with caution," and that there was no provable correlation when it came to Type 1 Diabetes.[44]

The AHRQ report also noted that many studies failed to adequately account for "confounders."[45] Due to the inability to conduct controlled studies, i.e., studies where individuals are randomly assigned to either breast or formula feeding, in this particular area, it is difficult to adequately account for other coexisting factors that are more likely to occur among mothers who breastfeed. This includes factors like higher income, more secure employment status, jobs that do not require physical labor, higher education, being married, living in safe and healthy neighborhoods, and better access to health care.[46] In the United States, each of these factors also correlates to race.[47]

In short, the very things that enable a woman to breastfeed are the same indicators of privilege that tend to result in better health outcomes for their infants and children. A study examined sibling pairs to eliminate such coexisting factors, and showed no statistical significance existed between those who were breastfed and those given formula for eleven different health outcomes including obesity, asthma, allergies, and diabetes.[48]

There are many reasons that the public perception remains that breastfeeding yields unquestionably better outcomes for infants. As

42. STANLEY IP, MEI CHUNG, GOWRI RAMAN, PRISCILLA CHEW, NOMBULELO MAGULA, DEIRDRE DEVINE, THOMAS TRIKALINOS & JOSEPH LAW, BREASTFEEDING AND MATERNAL AND INFANT HEALTH OUTCOMES IN DEVELOPED COUNTRIES, AHRQ PUBLICATION NO. 07-E007 (Apr. 2007).

43. *See* Stanley Ip, Mei Chung, Gowri Raman, Thomas A. Trikalinos & Joseph Lau, *A Summary of the Agency for Healthcare Research and Quality's Evidence Report on Breastfeeding in Developed Countries*, 4 BREASTFEEDING MED. (2009).

44. *See id.*

45. STANLEY IP, MEI CHUNG, GOWRI RAMAN, PRISCILLA CHEW, NOMBUELO MAGULA, DEIRDRE DEVINE, THOMAS TRIKALINOS, & JOSEPH LAUE, TUFTS- NEW ENGLAND MED. CTR. EVIDENCE-BASED PRACTICE CTR., AHRQ PUB. NO. 07-E007, BREASTFEEDING AND MATERNAL AND INFANT HEALTH OUTCOMES IN DEVELOPED COUNTRIES 3 (2007).

46. Colen & Ramey, *supra* note 40, at 56.

47. *Id.*

48. Eirik Evenhouse & Siobhan Reilly, *Improved Estimates of the Benefits of Breastfeeding Using Sibling Comparisons to Reduce Selection Bias*, 40 HEALTH SERV. RSCH. 1781, 1782, 1794–95 (2005).

Jung notes, medical journals are not interested in reporting when there is no correlation between the studied factor and the expected outcome, so studies showing benefits tend to get more attention than those showing none.[49] There is also the matter of how these benefits are reported. It is very hard for the average consumer of health information to contextualize what "double the risk" means in real terms when there is already a low risk for a particular disease or condition.[50] There is also a lack of rationality when discussing how to optimize outcomes for precious and vulnerable newborns and infants. The perception is that even if it is even slightly better for babies, then it should be compulsory.

Whatever the benefits of breastfeeding, nothing warrants the punitive treatment or shaming of women who have a medical reason for not breastfeeding, are physically or logistically unable to, or simply do not want to. More attention is being called to the mixed evidence regarding the superiority of breastfeeding, the stress women experience from the pressure to breastfeed, and the harmful impacts of the guilt and shame resulting when they are unable.[51]

2. Making the Choice Not to Breastfeed

Reproductive Justice demands that every person be given the resources and support to make the feeding decision they deem best for themselves and their child. This includes the decision not to breastfeed. Some might simply choose to prioritize their other caretaking responsibilities, furthering their education, or employment over breastfeeding.[52] For those who have paid employment, pumping breastmilk can take a significant professional toll, as work must be scheduled around the demands of one's body. But because of the presumptive benefits to babies, there is a heavy expectation that a woman will at least try.

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49. JUNG, supra note 3, at 82–83. This is known as "publication bias."

50. *Id.* at 101–02.

51. *See* Hanna Rosin, *The Case Against Breast-Feeding*, THE ATLANTIC (Apr. 2009), https://www.theatlantic.com/magazine/archive/2009/04/the-case-against-breast-feeding/307311/; Vivien K. Burt, Sonya Rasminsky, & Robin Berman, *Doctor Says: When it Comes to Breastfeeding, Your Health and Happiness Matters as Much as Your Baby's*, WASH. POST (Mar. 3, 2016), https://www.washingtonpost.com/news/parenting/wp/2016/03/03/doctor-says-when-it-comes-to-breastfeeding-your-health-and-happiness-matter-as-much-as-your-babys/.

52. Chinelo A. Ogbuanu, Janice Probst, Sarah B. Laditka, Jihong Liu, JongDeuk Baek & Saundra Glover, *Reasons Why Women Do Not Initiate Breastfeeding: A Southeastern State Study*, 19 WOMEN'S HEALTH ISSUES 268, 275 (2009).

Indeed, the fact that it is a decision that has to be justified is troublesome. Once again, parallels can be drawn to abortion. Just as there is the belief that there are "justifiable" reasons to have an abortion (which perpetuates stigma for those who have abortions for other reasons), there should not be categorizations of reasons women choose not to breastfeed.

Breastfeeding is often described as exhausting, painful, and inconvenient.[53] Although it is thought of as a "free" source of nutrition for infants, that presumes that the mother is readily available for frequent feedings, and that her time has no value. Jung estimates that breastfeeding consumes about 900 hours over six months, almost the equivalent of a full-time job.[54]

Mothers who are low-income, younger and Black are the least likely to breastfeed.[55] Hospital practices, aggressive formula marketing, family history, the need to work, and the lack of home support all contribute to low breastfeeding uptake and continuance.[56] One study, for example, showed that hospitals are nine times more likely to give Black mothers infant formula as compared to white mothers.[57] While this is also a form of reproductive oppression (the denial of a choice a mother might make if given adequate resources), extreme efforts to promote breastfeeding are equally abhorrent.

Jung describes a New York City policy that exhibited disrespect of mothers' decisions to formula feed.[58] Formula was required to be kept under "lock and key" and each request for formula was met with a required script from the attending nurse.[59] If the mother still wished to use formula, she was provided only enough for one feeding, and required to go through the processes for subsequent feedings.[60] This is reminiscent of abortion counseling requirements and waiting periods, which presume that women haven't given adequate thought to

53. Amy Brown, Jayne Rance & Paul Bennett, *Understanding the Relationship Between Breastfeeding and Postnatal Depression: The Role of Pain and Physical Difficulties*, 72 J. ADVANCED NURSING 273, 274-76 (Feb. 2016), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4738467/pdf/JAN-72-273.pdf.

54. JUNG, *supra* note 3, at 206–07 (for the woman who needs to return to work before an infant is weened, there are additional costs for supplies, which Jung estimates as close to $1,000).

55. *See generally*, Chelsea O. McKinney, Jennifer Hahn-Holbrook, P. Lindsay Chase-Lansdale, Sharon L. Ramey, Julie Krohn, Maxine Reed-Vance, Tonse N.K. Raju & Madeleine U. Shalowitz, *Racial and Ethnic Differences in Breastfeeding*, 138 PEDIATRICS 1, 2, 4 (2016).

56. *Id.* at 1, 5, 8.

57. *Id.* at 8.

58. JUNG, *supra* note 3, at 107.

59. *Id.*

60. *Id.*

their decision, and would change their mind if only provided the right information by people who know better.

The previous Section cites some of the enabling factors that support breastfeeding. A woman might consider the absence of any of those factors an insurmountable barrier that sways her decision to not breastfeed. Moreover, given that breastfeeding is a deeply personal decision that implicates a woman's bodily autonomy, a reason is not necessary.

3. Why Some Women are Unable to Breastfeed

While breastfeeding is often described as "natural," there are some women who cannot breastfeed. Many health conditions make it dangerous or inadvisable to breastfeed, including those requiring medications that would be passed to the breastfeeding infant, or HIV, which can be transmitted by breastfeeding.[61] Breast reduction surgery can also result in a reduced milk supply.[62] Some women are unable to breastfeed, despite their best efforts due to factors such as insufficient milk, delayed lactation, nipple pain and trauma, and infection.[63]

III. A BRIEF HISTORY OF BREASTFEEDING RECOMMENDATIONS

A complete history of human breastfeeding would begin with human origins. This paper only seeks to examine when breastfeeding became a focus of government regulation. It is not intended to provide a comprehensive timeline on government actions related to baby formula and breastfeeding recommendations, but identifies key points when the government was weighing in on the practice of breastfeeding, and making accompanying policy statements or regulations.

61. Eidelman & Schanler, *supra* note 41, at e827, e832–33.

62. *See generally R*oni Y. Kraut, Erin Brown, Christina Korownyk, Lauren S. Katz, Ben Vandermeer, Oksana Babenko, M. Shirley Gross, Sandy Campbell & G. Michael Allan, *The Impact of Breast Reduction Surgery on Breastfeeding: Systematic Review of Observational Studies*, 12 PLOS ONE e0186591, 2 (2017).

63. *See generally* Renate L. Bergmann, Karl E. Bergmann, Katharina von Weizsäcker, Monika Berns, Wolfgang Henrich & Joachim W. Dudenhausen, *Breastfeeding Is Natural But Not Always Easy: Intervention for Common Medical Problems of Breastfeeding Mothers-A Review of the Scientific Evidence*, 42 J. PERINATAL MED. 9, 9, 12, 15 (2014).

A. Pre-1970s: Breastmilk Substitutes and the Development of Formula

It has long been recognized that breastfeeding is not "easy" or "natural" for every woman.[64] Wet-nurses were essential to keeping alive those children whose mothers could not produce adequate milk.[65] Eventually, for women of a particular class, breastfeeding was viewed as unseemly, hence the common use of enslaved Black women as "wet-nurses."[66] Breastfeeding practices continued to fall along class lines that are the reverse of what is seen today: upper-class women were more likely to use substitutes, while those with limited resources breastfed.[67]

Evaporated cows' milk was the most common substitute in the 19th century, as it was readily available, and could be safely processed through pasteurization.[68] Formula emerged as "modern" societies were trying to use science and technology to improve upon everything.[69] Nutritionists and scientists identified key components in breastmilk, namely fats and carbohydrates, and sought to mimic these components by adding supplements to cows' milk.[70] The invention of formula revolutionized infant feeding, and created substantial profits from a process that had once been (technically) free.[71]

B. The 1970s: The Nestlé Scandal

On May 23, 1978, Americans watched from their living rooms as healthcare professionals lined up to testify at Edward Kennedy's televised Senate hearing on baby food marketing.[72] Baby formula companies, namely Nestlé, were finally being held accountable for the infant

64. *See generally*, Kathleen A. Marinelli, *Wet Nurses to Donor Milk Banks and Back Again: The Continuum of Sharing our Milk to Save Lives*, 36 J. HUM. LACTATION 213 (2020), https://journals.sagepub.com/doi/full/10.1177/0890334420927329.

65. *Id.* at 213.

66. *Id.*

67. JUNG, *supra* note 3, at 28.

68. Andrew J. Schuman, *A Concise History of Infant Formula (Twists and Turns Included),* CONTEMP. PEDIATRICS (Feb. 1, 2003), https://www.contemporarypediatrics.com/view/concise-history-infant-formula-twists-and-turns-included.

69. *Id.*

70. Schuman, *supra* note 68; *see also* Farryl Bertmann, Caroline Glagola Dunn, Elizabeth F. Rancine & Sheila Fleischhacker, *The Risk of Homemade Infant Formulas: Historical and Contemporary Considerations*, 2021 J. ACAD. NUTRITION & DIETETICS (2021); Emily E. Stevens, Thelma E. Patrick & Rita Pickler, *A History of Infant Feeding*, 18 J. PERINATAL EDUC. 32, 36 (2009), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2684040/.

71. *See infra* Section IV.C.2. Breastfeeding is only free if women's time has no value.

72. JUNG, *supra* note 3, at 45.

deaths that their misguided ad campaigns had caused by encouraging mothers to formula-feed when they had little or no access to clean drinking water and sanitation.[73] This shifted the tide of public opinion in favor of breastfeeding after almost a century of formula being touted as the "modern" mother's solution to feeding her children.[74] Therefore, the government had to reestablish norms of breastfeeding through public education and policy.

One main avenue of governmental action was through allocating funding to the Special Supplemental Nutrition Program for Women, Infants and Children (WIC).[75] WIC started as a pilot project in 1972, and became a permanent program in 1975 as part of the USDA's efforts to provide food for low-income families who were nutritionally at-risk.[76] By the end of the 1980s, WIC counselors were instructed to encourage breastfeeding as the best option for infant nutrition.[77]

C. The 1990s: Breastfeeding as a Matter of Public Health

Beginning in the 1990s, breastfeeding was reframed as a public health issue: if mothers chose not to breastfeed, they were endangering infant health. In 1992, Congress required that the Secretary of Agriculture establish a national program to promote breastfeeding as the best method of infant nutrition.[78] This was followed by the 2000 United States Department of Health and Human Services (HHS) publication, *Blueprint for Action on Breastfeeding*, urging doctors, employers and child care facilities to develop policies that encouraged women to breastfeed for longer.[79] This report framed breastfeeding as an essential means for mothers to save their children from all sorts of illnesses and chronic health issues such as diabetes and leukemia, despite the scant evidence discussed in Section II.C.1.

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73. *Id.*

74. *Id.* at 43.

75. *Id.* at 44.

76. *Legislative History of Breastfeeding Promotion Requirements in WIC*, U.S. DEP'T OF AGRIC.: FOOD & NUTRITION SERV. (Oct. 18, 2013), https://www.fns.usda.gov/wic/legislative-history-breastfeeding-promotion-requirements-wic.

77. *Id.*

78. *Id.*

79. *See HHS Blueprint for Action on Breastfeeding*, U.S. BREASTFEEDING COMM. (last visited Feb. 3, 2022), http://www.usbreastfeeding.org/p/cm/ld/fid=222.

D. 2009 and Beyond: Breastfeeding as an Emerging Duty

Responding to the *Blueprint*, Dr. Regina Benjamin claimed in 2010 that "for far too long, breastfeeding has received insufficient national attention as a public health issue."[80] Her call to action began with a description of the many benefits of breastfeeding, but then launched into a lengthy list of costs that failing to breastfeed imposes on society as a whole.[81] "Better infant health means fewer health insurance claims, less employee time off to care for sick children, and higher productivity, all of which concern employers."[82] This legitimized framing breastfeeding as a public health issue rather than a matter of individual choice; formula feeding became equitable with other lifestyle choices that were perceived as driving up healthcare costs, "just like unsafe sex, smoking and unhealthy eating."[83]

Dr. Benjamin galvanized a new wave of more targeted, demographic-specific initiatives to incentivize breastfeeding. The Healthy, Hunger-Free Kids Act of 2010 focused on low-income mothers, requiring that the USDA provide performance bonuses to state agencies based on breastfeeding rates.[84] The USDA began allocating additional funding to WIC for prenatal breastfeeding counseling, educational materials, breast pumps and supplies, and began its enhanced food packages program in 2009.[85] This last program was a system of incentives where women who "fully breastfed" their children would receive larger food packages, for longer, and with more variety of food, than women who partially or did not breastfeed.[86] This regulation will be further explored in Section IV. The USDA then advised WIC counselors to prioritize certification of breastfeeding mothers and children over non-breastfeeding mothers and children.[87] Because WIC is a non-entitlement program (meaning it only serves clients up to the point when funding runs out), prioritizing breastfeeding

80. JUNG, *supra* note 3, at 100.
81. *Id.*
82. *Id.*
83. *Id.* at 123.
84. *Healthy, Hunger-Free Kids Act of 2010: The Role of State Health Agencies in Ensuring Access to Healthy Food*, ASS'N OF STATE AND TERRITORIAL HEALTH OFFICIALS 1 (2012), https://www.astho.org/Programs/Prevention/Obesity-and-Wellness/Hunger-Free-Kids-Act-Issue-Brief/#:~:text=the%20purpose%20is%20to%20increase,%2C%20and%20Children%20(WIC).&text=WIC%20electronic%20benefit%20transfer%20(EBT,nationwide%20by%20October%201%2C%202020.
85. U.S. DEP'T AGRIC.: FOOD & NUTRITION SERV., *supra* note 75.
86. *Id.* at 111.
87. *Id.*

mothers meant that non-breastfeeding mothers could be turned away from WIC for that reason.[88] This created a system of penalties where low-income mothers who could not, or chose not to breastfeed were forced to put their families at risk of either receiving diminished WIC food packages, or none at all. Fortunately, despite WIC not being an entitlement program, its budget has been fully funded, allowing all families who fall below the income threshold to participate.[89]

Other initiatives targeted Women of Color as the Centers for Disease Control and Prevention (CDC) began highlighting data revealing that African American women do not initiate breastfeeding as much, or continue breastfeeding as long, as white women.[90] In spite of the facts that employment status has a greater effect on breastfeeding rates than race, and that the racial gap has narrowed to 15% in recent years,[91] the CDC consistently highlights racial differences as a key factor in breastfeeding disparities,[92] calling for "more targeted strategies to increase breastfeeding support for African American mothers."[93] HHS has responded to these calls through specifically designed breastfeeding interventions targeting African American and Indigenous women.[94]

Many of these interventions, though framed as well-intentioned efforts to reduce racial disparities in breastfeeding, end up reinforcing racial stereotypes and "send[ing] strong messages about which demographics parent best- and worst."[95] This messaging is exemplified in HHS' *Your Guide to Breastfeeding for African American Women* and an *Easy Guide to Breastfeeding for American Indian and Alaska Native Families*.[96] These are essentially the same as other non-

88. *Id.*

89. BREAD FOR THE WORLD INST., APPLYING RACIAL EQUITY TO U.S. FEDERAL NUTRITION ASSISTANCE PROGRAMS: SNAP, WIC & CHILD NUTRITION 29 (Feb. 2019), https://www.paperturn-view.com/us/bread-for-the-world/applying-racial-equity-to-u-s-federal-nutrition-assistance-programs?pid=ntg58712&v=3.

90. *See More Mothers are Breastfeeding: African American Mothers Need More Support*, CTRS. FOR DISEASE CONTROL & PREVENTION (Feb. 7, 2013), cdc.gov/media/releases/2013/p0207_breast_feeding.html.

91. JUNG, *supra* note 3, at 116.

92. *Id.*

93. *Id.*

94. *See* U.S. DEP'T OF HEALTH AND HUMAN SERVS., OFF. ON WOMEN'S HEALTH, AN EASY GUIDE TO BREASTFEEDING FOR AFRICAN AMERICAN WOMEN (2006); *see also* U.S. DEP'T OF HEALTH AND HUMAN SERVS., OFF. ON WOMEN'S HEALTH, AN EASY GUIDE TO BREASTFEEDING FOR AMERICAN INDIAN AND ALASKA NATIVE FAMILIES (2006).

95. JUNG, *supra* note 3, at 119.

96. *See* U.S. DEP'T OF HEALTH AND HUMAN SERVS., OFF. ON WOMEN'S HEALTH, AN EASY GUIDE TO BREASTFEEDING FOR AFRICAN AMERICAN WOMEN (2006); *see also* U.S. DEP'T OF

audience specific publications to encourage breastfeeding, but these guides skip the scientific evidence of the health benefits of breastfeeding, and simply state that "[b]reastfeeding offers so many benefits for families" and warns that women living with HIV/AIDS and mothers who use "street drugs" should not breastfeed.[97]

These guides also overlook factors that might make heavy emphasis on breastfeeding ill-advised; for example, how a mother's lack of access to clean air, water, and nutrition might place her breastfeeding infant at risk.[98] In spite of targeted studies revealing "that the overwhelming reason [African American] women" do not breastfeed is that they "prefer to bottle feed," the CDC has postulated that "[B]lack women may lack culturally relevant information, hold perceptions that breastfeeding is inferior to infant formula feeding, may lack social or partner support and knowledge of the health benefits associated with breastfeeding."[99] Stated differently, they attribute their preference to "misinformation, misperception, and ignorance of their partners and community."[100] They do not study why white women prefer bottle feeding.[101]

Today, U.S. breastfeeding rates are on par with those in countries that are lauded for being leaders in parental and breastfeeding support; almost twice as many American mothers breastfeed at six months in comparison to mothers in Norway.[102] The goals of the Healthy, Hunger-Free Kids Act of 2010 were surpassed both in terms of initiation and duration.[103] Still, breastfeeding advocacy campaigns pitch the U.S. as being woefully behind when it comes to breastfeeding.[104] Jung attributes this to the fact that it is convenient to displace the persisting policy shortcomings surrounding parental support and childhood illness on parents.[105] "By recasting the problem of Ameri-

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HEALTH AND HUMAN SERVS., OFF. ON WOMEN'S HEALTH, AN EASY GUIDE TO BREASTFEEDING FOR AMERICAN INDIAN AND ALASKA NATIVE FAMILIES (2006).

97. *Id.*

98. SANDY LANGELIER, NATIVE WOMEN MUST MAKE THEIR OWN CHOICES ABOUT BREASTFEEDING, YWCA (Aug. 2, 2016), http://ywca-nm.org/native-women-must-make-choices-breastfeeding/.

99. Rachel Lorenzo, *Native Women Must Make Their Own Choices About Breastfeeding*, THE HILL (June 30, 2016), https://thehill.com/blogs/congress-blog/healthcare/285996-native-women-must-make-their-own-choices-about-breastfeeding.

100. JUNG, *supra* note 3, at 119.

101. *Id.*

102. *Id.* at 202; *see also Breastfeeding Rates*, CTRS. FOR DISEASE CONTROL & PREVENTION (Aug. 2, 2021), https://www.cdc.gov/breastfeeding/data/nis_data/results.html.

103. JUNG, *supra* note 3, at 201.

104. *Id*. at 210.

105. *Id.*

can healthcare as a problem of unhealthy and irresponsible individuals . . . public health officials . . . distinguish[ ] between 'good' and 'bad' citizens. The bad citizens not only bring on their own health problems; they are also responsible for the soaring cost of healthcare in general."[106]

IV. A CLOSER LOOK AT THE WIC BREASTFEEDING REGULATION

A. What Is WIC?

WIC has been an essential part of improving health outcomes for mothers and infants since its inception in 1974.[107] The mission of WIC is "to safeguard the health of low-income pregnant, postpartum, and breastfeeding women, infants, and children up to age five who are at nutritional risk by providing nutritious foods to supplement diets, information on healthy eating including breastfeeding promotion and support, and referrals to health care."[108] WIC participation leads to more nutritious diets for families, higher birth-weight in infants, and better school performance for children.[109] Unlike SNAP, which provides an amount of money for participants to purchase foods, WIC is administered through set "food packages" which are specific amounts and categories of foods, like produce, cereal, and milk.[110]

WIC is an income-based program funded by the federal government but administered by the states.[111] The federal government sets the maximum eligibility at 185% of the federal poverty level.[112] In 2022, for a family of three, this is $42,605.[113] While states are permitted to be less generous and can set eligibility as low as the federal

106. *Id.*

107. *About WIC*, U.S. DEP'T AGRIC.: FOOD & NUTRITION SERV. (July 27, 2021), https://www.fns.usda.gov/wic/about-wic.

108. *Id.*

109. Steven Carlson & Zoë Neuberger, *WIC Works: Addressing the Nutrition and Health Needs of Low-Income Families for More Than Four Decades*, CTR. ON BUDGET & POL'Y PRIORITIES 5, 26 (2021), https://www.cbpp.org/sites/default/files/atoms/files/5-4-15fa.pdf.

110. *Enhancing the WIC Food Package Impacts and Recommendations to Advance Nutrition Security*, NAT'L WIC ASS'N 1, 7 (2021), https://s3.amazonaws.com/aws.upl/nwica.org/nwa-wic-food-package-report.pdf. This package is revised every five years or so, in accordance with nutrition science.

111. *WIC Funding and Program Data*, U.S. DEP'T AGRIC.: FOOD & NUTRITION SERV. (Feb. 18, 2021), https://www.fns.usda.gov/wic/wic-funding-and-program-data.

112. *WIC 2021-2022 Income Eligibility Guidelines*, U.S. DEP'T AGRIC.: FOOD & NUTRITION SERV. (Mar. 15, 2021), https://www.fns.usda.gov/wic/2021-2022-income-eligibility-guidelines.

113. *Poverty Guidelines*, U.S. DEP'T AGRIC.: FOOD & NUTRITION SERV. (Jan. 12, 2022), https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines.

poverty level (currently $23,030),[114] all states currently receive grants based on the percentage of the population at 185% FPL.[115]

Poverty in the U.S. is closely correlated to race due to a number of both historic and current factors.[116] Furthermore, structural racism plays a critical role in the factors that contribute to food insecurity.[117] As a result, as compared to their populations in the U.S., Black and Hispanic families are overrepresented in WIC, while white families are underrepresented.[118] White and Black participants each constitute 29.4% of those receiving WIC, while 41.1% of participants are Hispanic.[119] Only 57% of all eligible families actually participate in the program, meaning that WIC could be doing more to address hunger among low-income people in the U.S.[120]

B. The Breastfeeding Regulation

The WIC program has always distinguished between mothers who are breastfeeding and those who are not. Periodic revisions to the program have furthered support for breastfeeding by funding breastfeeding promotion and assistance, providing breast pumps, and requiring data collection on breastfeeding rates, as well as by providing enhanced food packages based on breastfeeding status.[121]

The USDA regulations proposing different food packages based on a mother's breastfeeding frequency was based on 2005 recommen-

114. *Id.*; *WIC Eligibility Requirements*, U.S. DEP'T AGRIC.: FOOD & NUTRITION SERV. (June 19, 2020), https://www.fns.usda.gov/wic/wic-eligibility-requirements. For each state's income eligibility requirements, *see HHS Poverty Guidelines for 2022*, OFF. OF THE ASSISTANT SEC'Y FOR PLANNING & EVALUATION, https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines (last visited Feb. 22, 2022).

115. *WIC Funding and Program Data*, U.S. DEP'T AGRIC.: FOOD & NUTRITION SERV (Feb. 18, 2021), https://www.fns.usda.gov/wic/wic-funding-and-program-data.

116. *See* APPLYING RACIAL EQUITY TO U.S. FEDERAL NUTRITION ASSISTANCE PROGRAMS: SNAP, WIC AND CHILD NUTRITION, BREAD FOR THE WORLD INST. 5 (Feb. 21, 2019), https://www.paperturn-view.com/us/bread-for-the-world/applying-racial-equity-to-u-s-federal-nutrition-assistance-programs?pid=NTg58712&v=3.

117. *Id.*

118. *Id.* at 29.

119. USDA FOOD AND NUTRITION SERV., OFF. OF POL'Y SUPPORT, NATIONAL- AND STATE-LEVEL ESTIMATES OF WIC ELIGIBILITY AND WIC PROGRAM REACH IN 2018 WITH UPDATED ESTIMATES FOR 2016 AND 2017 VOLUME I, 36 (2021), https://fns-prod.azureedge.net/sites/default/files/resource-files/WICEligibles2018-VolumeI.pdf.

120. *Women, Infants, and Children (WIC) Program Eligibility and Participation*, U.S. CENSUS BUREAU (Aug. 17, 2021), https://www.census.gov/library/visualizations/interactive/wic-eligibility-participation.html#:~:text=USDA's%20Food%20and%20Nutrition%20Service,population%20is%20participating%20in%20WIC.

121. U.S. DEP'T OF AGRIC., *supra* note 75.

dations by the Institute of Medicine.[122] This change was made at the same time the WIC program was undergoing substantial revisions to ensure that participants were receiving healthier food.[123] In order to incentivize breastfeeding, the WIC program provides less food to the infants of mothers who do not breastfeed, or breastfeed only sometimes.[124] The program also provides different food packages for mothers based on whether they are breastfeeding, and extends eligibility to one year post-partum for women who are breastfeeding.[125]

WIC provides "enhanced" food packages for the infants of mothers who breastfeed, with the goal being to provide a financial incentive to choose breastfeeding over formula feeding.[126] A brochure provided by the WIC Program makes it clear that women who do not breastfeed have to pay significantly more to purchase the foods their infants need in order to receive adequate nutrition.[127] Women who fully breastfeed need only an additional $7 to meet their infant's nutritional needs.[128] Women who mostly breastfeed require $26 per month, and those who formula feed will pay an additional $115 per month to provide adequate nutrition for their children.[129]

The enhanced food packages are not simply tailored to meet the different needs of infants who nurse versus those who do not. The non-enhanced package purposely leaves low-income women to meet their infants' nutritional needs out-of-pocket. This is an additional financial burden on low-income mothers who are already dealing with the stress of infant care.

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122. Special Supplemental Nutrition Program for Women, Infants and Children (WIC): Revisions in the WIC Food Packages, 71 Fed. Reg. 44784, 44784 (Aug. 7, 2006) (to be codified at 7 C.F.R. pt. 246) (citing *WIC Food Packages: Time for a Change*, NAT'L ACAD. SCIS. 1, 14 (2006), https://www.nap.edu/download/11280).

123. WIC FOOD PACKAGES: TIME FOR A CHANGE (2005), https://www.nap.edu/download/11280.

124. The current version of this rule is, Special Supplemental Nutrition Program for Women, Infants and Children (WIC): Revisions in the WIC Food Packages, 79 Fed. Reg. 12274, 12292 (Mar. 4, 2014) (to be codified at 7 C.F.R. pt. 246.

125. *Id*. Because women who are breastfeeding need additional calories, this differential treatment is perhaps justified, but beyond the scope of this paper.

126. State program materials typically include an illustration of the greater amount of food provided to infants of breastfeeding mothers, and emphasizes the cost differential between fully breastfeeding, partially breastfeeding and non-breastfeeding food packages. *See, e.g.*, Indiana WIC (@IndianaWIC), TWITTER (May 19, 2020 2:35PM), https://twitter.com/indianawic/status/1262814190621859856.

127. *WIC Food Packages for Your Baby*, DC DEP'T OF HEALTH, https://doh.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/Wic_Food_Packages_For_Moms__Babies_English.pdf.

128. *Id*.

129. *Id.*; *see* Figure 1.

By definition, women who are WIC-eligible are financially struggling. For example, the income eligibility for WIC for a family of three in DC is $40,626[130], but in DC, the vast majority of participants are well below this threshold.[131] As new mothers, their ability to work, even once recovered from the physical impact of childbirth, is severely curtailed by the need to care for their newborns, or to secure affordable childcare. At a time when they are still caring for infants or scrambling for affordable childcare to enable them to work[132], a greater portion of new mothers' extremely limited budgets must go to purchasing essential food items for their babies.

Requiring an impoverished new mother to find up to $115 per month to adequately feed her infant because she cannot or chooses not to breastfeed is unduly punitive and undermines the goals of WIC. The regulation that intended to incentivize breastfeeding instead leaves infants vulnerable to hunger, and cannot be justified by any overwhelming health benefit provided by breastfeeding.

C. Does the Formula Penalty Make a Difference in Breastfeeding Uptake?

There are mixed reports as to whether the formula penalty and enhanced food package makes a significant difference in women's breastfeeding decisions.[133] A study commissioned by the U.S. Food and Nutrition Service, which oversees the WIC Program, showed that the enhanced food package for mothers who exclusively breastfeed

130. INCOME ELIGIBILITY GUIDELINES, WIC DC, https://www.unityhealthcare.org/docs/default-source/default-document-library/8-006a-ieg_fy2022-(1).pdf?sfvrsn=86a10793_2 (last updated June 2021).

131. While D.C.-specific data is not available, according to the most recent national available, 45% of all Black WIC participants had incomes at 0% to 50% of the Federal Poverty Guidelines. *See* U.S. DEP'T AGRIC., FOOD & NUTRITION SERV., WIC PARTICIPANT AND PROGRAM CHARACTERISTICS 2018, 1, 42–43 (2020), https://fns-prod.azureedge.net/sites/default/files/resource-files/WICPC2018.pdf; WIC PARTICIPANT AND PROGRAM CHARACTERISTICS 2018: FINAL REPORT, U.S. DEP'T AGRIC., FOOD & NUTRITION SERV., (May 6, 2020), https://www.fns.usda.gov/wic/participant-and-program-characteristics-2018-charts#2. According to the most recent data available (2016) 73% of all WIC participants in D.C. are Black. POLICY SNAPSHOT: WOMEN, INFANTS, AND CHILDREN (WIC) PROGRAM, DC ACTION 6 (2021) https://www.wearedcaction.org/sites/default/files/2021-02/2021%20WIC%20Snapshot.pdf.

132. The District of Columbia has some of the highest childcare costs in the nation. *How Does Your State Stack Up? Annual Infant Care Costs*, ECON. POLICY INST., https://www.epi.org/how-does-your-state-stack-up-annual-infant-care-costs/ (last visited Apr. 30, 2022).

133. KATHLEEN M. RASMUSSEN, MARIE E. LATULIPPE & ANN L. YAKTINE, REVIEW WIC FOOD PACKAGES PROPOSED FRAMEWORK FOR REVISIONS: INTERIM REPORT, NAT'L ACADS. OF SCI., ENG'G, & MED. 235–56 (2016) (examining, in chapter seven, studies suggest that enhanced food packages and additional breastfeeding support yielded a "small effect" on breastfeeding outcomes), https://www.ncbi.nlm.nih.gov/books/NBK379063/.

was not having the desired outcome of increasing breastfeeding initiation.[134] According to the study, "the breastfeeding initiation rate for WIC participants was essentially unchanged at 65.5% (pre-implementation) and 65.1% (post-implementation)."[135]

Smaller studies of the WIC changes reported more positive results. A study of New York WIC participants showed that the percentage of mothers who initiated breastfeeding increased from 72.2% to 77.5%.[136] While the food package might have been the motivator, the WIC program also implemented other campaigns and programs to support breastfeeding at the same time.[137] Indeed, a small study in Southern California showing an 86% increase in the number of women exclusively breastfeeding attributes that increase more to the additional support from trained WIC staff, rather than the financial incentive of a larger food package.[138] The authors note that the full financial benefit of the enhanced food package is not seen until the infant turns 6 months old, therefore making it unlikely that it was a motivator at the time of breastfeeding initiation.[139]

V. ADVANCING REPRODUCTIVE JUSTICE IN THE WIC PROGRAM

According to the most recent data available, there is a significant disparity in the breastfeeding rates of WIC eligible women; only 37% of African Americans participants breastfeed, while 57% of whites and 74% of Latinas do.[140] It is critical that Black women who are participating in WIC be given the same opportunity and support to breastfeed. Strengthening support for breastfeeding by Black women is a laudable goal,[141] but given the shame and stigma experienced by

134. Parke Wilde, Anne Wolf, Meena Fernandes & Ann Collins, *Food-Package Assignments and Breastfeeding Initiation Before and After a Change in the Special Supplemental Nutrition Program for Women, Infants, and Children*, 96 AM. J. CLINICAL NUTRITION 560, 564 (2012), https://academic.oup.com/ajcn/article/96/3/560/4576820.

135. *Id.*

136. Mary Ann Chiasson et al., *Changing WIC Changes What Children Eat*, 21 OBESITY 1423, 1425 (2013), https://onlinelibrary.wiley.com/doi/epdf/10.1002/oby.20295.

137. *Id.*

138. Shannon E. Whaley, Maria Koleilat, Mike Whaley, Judy Gomez, Karen Meehan & Kiran Saluja, *Impact of Policy Changes on Infant Feeding Decisions Among Low-Income Women Participating in the Special Supplemental Nutrition Program for Women, Infants, and Children*, 102 AM. J. PUB. HEALTH 2269, 2271 (2012), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3519334/.

139. *Id.* at 2272.

140. BREAD FOR THE WORLD INST., *supra* note 116, at 34.

141. *Id.* at 34–35.

those who cannot or chose not to breastfeed, support cannot become another means of inflicting guilt. As breastfeeding researchers Colen & Ramey note:

> [e]fforts to increase breastfeeding that solely focus on individually based behavior change without addressing the economic and social realities women face and the difficult tradeoffs they are forced to make in the months following the birth of their child risk alienating and stigmatizing the very women they hope to help.
>
> . . .
>
> A truly comprehensive approach to increasing breastfeeding in the U.S., with a particular focus on reducing racial and SES disparities, will need to work toward increasing and improving parental leave policies, flexible work schedules and health benefits even for low-wage workers, and access to high quality child care that can ease the transition back to work for both mother and child. Hopefully, this multifaceted approach will allow women who want to breastfeed to do so for as long as possible without promoting a cult of "total motherhood" in which women's identities are solely constructed in terms of providing the best possible opportunities for their children and the risks associated with a failure to breastfeed are drastically overstated.[142]

Often, reproductive oppression results because interventions focus on individual behaviors and policies that make presumptions about individuals' life circumstances. Many solutions to advance Reproductive Justice call for close consideration of individual factors and a tailoring of solutions to meet individual needs. Typically, these types of interventions are impracticable given the resources or ability of systems to respond in such an individualized and holistic manner. Such is not the case with the WIC program. A prominent feature of the program is breastfeeding and nutrition counseling, meaning that each participant can be assessed to determine whether her life circumstances or health make breastfeeding challenging or impossible.[143] While such requirements to receive government support are justifiably criticized as unnecessarily intrusive and paternalistic,[144] in this in-

142. Colen & Ramey, *supra* note 40, at 64.

143. THE SPECIAL SUPPLEMENTAL NUTRITION PROGRAM FOR WOMEN, INFANTS AND CHILDREN (WIC PROGRAM), U.S. DEP'T AGRIC., https://fns-prod.azureedge.net/sites/default/files/wic/wic-fact-sheet.pdf (last visited Feb. 2, 2022).

144. *See generally* KHIARA BRIDGES, THE POVERTY OF PRIVACY RIGHTS (2017) (examining range of government interventions in the lives of low-income families); *see also* JUNG, *supra* note 3, at 113–14 (describing onerous recertification requirements, mandatory parenting counseling and demeaning treatment by program staff).

stance they present the opportunity for consideration of individual circumstances in a way that is typically not feasible in other situations.

The WIC regulation, which requires women who cannot or choose not to breastfeed to pay substantially more to feed their infants, is a misguided attempt to make breastfeeding compulsory.[145] There is little evidence that it has been effective in its goal. New mothers should be encouraged to breastfeed with a "carrot"—encouragement and support, and not a "stick"—financial penalties. A supportive environment and guidance when met with common barriers to breastfeeding go far in improving initiation and continuation rates. One study showed an 83.8% initiation rate at "Baby Friendly" hospitals, as compared to a rate of 69.5% in the U.S. generally.[146] Racial disparities in breastfeeding rates virtually disappeared with supportive hospital practices, such as having the staff trained on implementing a written breastfeeding policy, helping mothers breastfeed within an hour of birth, and allowing babies to stay in the hospital room with their mothers.[147] There is also room for improvement with regard to cultural competence, especially as it pertains to trauma informed counseling and barriers resulting from structural racism.[148] Full implementation of proven practices will likely have the desired effect of increasing breastfeeding uptake and continuance, but the financial penalty imposed on low-income mothers is unacceptable.

VI. CONCLUSION

The decision whether or not to breastfeed is a matter of Reproductive Justice. As with all mothers, those who receive WIC benefits should have every opportunity and all the support needed to make this feeding choice for their infants. Nonetheless, babies should not suffer because their mothers cannot breastfeed due to health issues, or simply choose not to in consideration of their other life circumstances. The regulation which imposes a financial penalty on families based on mothers' breastfeeding status should be repealed.

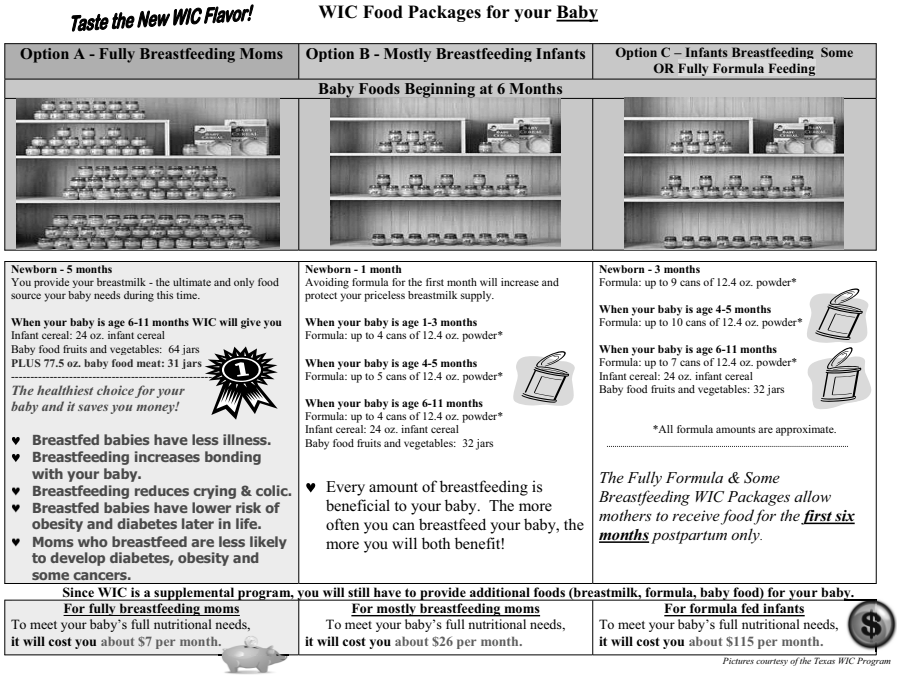
145. JUNG, *supra* note 3, at 114.

146. Anne Merewood, Supriya D. Mehta, Laura Beth Chamberlain, Barbara L. Philipp & Howard Bauchner, *Breastfeeding Rates in US Baby-Friendly Hospitals: Results of a National Survey*, 116 PEDIATRICS 628, 628 (2005).

147. *Id.* at 629.

148. BREAD FOR THE WORLD INST, *supra* note 116, at 35–36.

Figure 1. Food Packages for Infants Based on Mothers' Breastfeeding Frequency



Speech on Trial? An Exploration into the Effects of Lingual Discrimination on African American Vernacular English Speakers

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> Working for Justice can take many forms, but for linguists, we believe it should include listening to vernacular dialects more closely and hearing their speakers more clearly and more fairly, not only in courtrooms, but also in schools, job interviews, apartment searches, doctors' visits, and everywhere that speech and language matter.
>
> -John Rickford[1]

ABSTRACT

Linguistic discrimination is one of the last socially acceptable ways to discriminate. Criticizing nonstandard dialects can act as a proxy for criticizing the speaker or for denying the speaker meaningful access to important institutions such as the legal system. This Note explores the effects of linguistic discrimination of African American Vernacular En-

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1. John R. Rickford & Sharese King, *Language and Linguistics on Trial: Hearing Rachel Jeantel (and Other Vernacular Speakers) in the Courtroom and Beyond*, 92 LANGUAGE 948, 949 (2016).

glish (AAVE) speakers and offers suggestions on how to eradicate it for two major legal decision makers: judges and jurors. For example, creating a feedback/auditing system that would hold judges, an important actor in the legal sphere, accountable for protecting vulnerable AAVE speakers. Most of the solutions can work to help eradicate more mainstream versions of lingual discrimination, but this Note focuses on the African American community in the United States.

I. INTRODUCTION

When Black people speak colloquially, the term "dog," sometimes spelled "dawg," very rarely refers to an actual, literal dog.[2] In 2015, when twenty-two year old Warren Demesme was voluntarily agreed to speak to New Orleans police department after being accused of sexual assault by two young girls, he told police officers in the interrogation room, "I know that I didn't do it so why don't you just give me a lawyer dog 'cause this is not what's up."[3] Later, prosecutors claimed that the police officers interrogating Demesme thought that

2. According to Merriam-Webster, the definition of "dawg" is "man, buddy, dude." *See also* Torres v. Kernan, No. 16CV0870-MMA (AGS), 2017 WL 3605334, at *6 (S.D. Cal. Aug. 22, 2017) (recognizing that Defendant's statement "they swung on me, dawg," was Defendant "using the slang term 'dawg' instead of 'dog.'").

3. *Hearsay*, 104 ABA J. 15, 15 (2018); *see also* Norman Tabler, *The Unspeakable Comma*, 65 FED. LAW. 18, 18 (2018); Caleb L. Green, Esq., *Upholding the Constitution Through Diversity*, 29 NEV. LAW. 16, 16-17 (2021); *see also* Dennis Baron, *Miranda and the Louisiana Lawyer Dog: A Case of Talking While Black*, BLOGS.ILLINOIS.EDU (Nov. 4, 2017, 10:00 AM), https://blogs.illinois.edu/view/25/574827.

he was asking for a literal "lawyer dog" and not invoking his constitutionally mandated right to counsel.[4] Because of this, police officers did not comply with Demesme's request[5] and continued to interrogate him.[6] Demesme subsequently admitted to the crime.[7] His treatment directly contradicts the Supreme Court precedent that states interrogations must unequivocally end when the accused asks for a lawyer,[8] yet the Louisiana Supreme Court infamously declined to hear Demesme's case on appeal when he finally did receive an attorney.[9]

Two years prior to Demesme's interrogation in Louisiana, George Zimmerman went on trial for the murder of Trayvon Martin in Florida.[10] One of Martin's friends, Rachel Jeantel, testified as a witness for the prosecution.[11] Jeantel's testimony was critical to the prosecution's case, but it was castigated in the press and on social media due to Jeantel speaking in African American Vernacular English (AAVE) amongst other forms of Black English.[12] This case, in which the vernacular, or non-standard dialect, of a key witness was essentially on trial, highlights an injustice. Not only was Jeantel's vernacular pivotal in the disregard of her critically important testimony in this case, but critics went so far as to make judgements on her intelligence level simply due to how she spoke.[13]

Demesme's and Jeantel's treatment in their respective courts both speak to the same general problem. Jeantel's experience highlights the fact that mainstream English speakers can misunderstand and/or discredit vernacular speakers when they encounter dialectic unfamiliarity. Jeantel's speech was ridiculed, which lead to negative

4. Green, *supra* note 3.

5. Tabler, *supra* note 3.

6. Erik De La Garza, *Louisiana Court Finds Suspect's 'Lawyer Dog' Request Falls Short*, COURTHOUSE NEWS SERV. (Nov. 1, 2017), https://www.courthousenews.com/louisiana-court-finds-suspects-lawyer-dog-request-falls-short/.

7. *Id.*

8. Edwards v. Arizona, 451 U.S. 477, 481-82 (1981) (holding that once a defendant invokes his Sixth Amendment right to counsel, police must cease custodial interrogation until an attorney is present)

9. *See generally* State v. Demesme, 228 So.3d 1206 (La. 2017).

10. *Compare* Rickford & King, *supra* note 1, at 948 (explaining that George Zimmerman went on trial for killing Trayvon Martin in 2013) *with* Ryan Niedermair, *I Coulda Had a Lawyer: Why States Should Abandon the Davis Standard When Analyzing Ambiguous Custodial Requests for Counsel*, 93 TUL. L. REV. ONLINE 29, 30 (2019) (explaining that Warren Demesme was interrogated by Lousiana police in 2013).

11. Rickford & King, *supra* note 1, at 948.

12. *See generally* Amanda Carlin, *The Courtroom as White Space: Racial Performance as Noncredibility*, 63 UCLA L. REV. 450, (2016).

13. *Id.*

assumptions about her intelligence and credibility.[14] On the other hand, Demesme's AAVE was intelligible enough to communicate a confession,[15] but not enough to secure his constitutionally guaranteed rights. These stories share a theme of vernacular English speakers being misheard and/or maligned. Looking beyond these two cases in the legal system—speaking AAVE, or really any non-mainstream variety of speech, in the United States likely exacerbates biases rooted in race and class in cross-dialect domains such as schools,[16] housing searches,[17] finding employment,[18] and as I will discuss mainly here, the criminal justice system. Non-mainstream dialectic speakers are much more vulnerable to being misheard and misjudged by police, judges, juries, teachers, landlords, doctors, and employers in everyday life than speakers of standard or mainstream varieties.[19]

Even though we can study the effects of linguistic discrimination broadly, the legal system is the necessary starting point. The outcomes of decisions made within the legal arena usually have long last-

14. Mikah K. Thompson, *Blackness as Character Evidence*, 20 MICH. J. RACE & L. 321, 340–41 (2015) ("Juror B-37's assumption that Jeantel's speech and reading skills were the result of poor education or a lack of intelligence demonstrate the application of White-specific and American-specific expectations that all people living in the United States must be able to speak and read [standard American] English, unless they are too unintelligent to do so.").

15. Green, *supra* note 3 ("The officers. . . continued to question Demesme, and later used his statements during the conversation to convict him.").

16. *See* William Y. Chin, *Linguistic Profiling in Education: How Accent Bias Denies Equal Educational Opportunities to Students of Color*, 12 SCHOLAR 355 (2010) (arguing that linguistic-based bias is found within the education system against "accented" Black speakers by denying them access to charter schools, placing them in low ranked classes, and also through other means such as teachers calling on them less, being made to question their own identity, and also through being given lower grades); *see also* Kali Jensen, *The Plain English Movement's Shifting Goals*, 13 J. GENDER RACE & JUST. 807, 820 (2010) ("Linguistic minorities often struggle in school because their dialect is not accepted, which causes them to struggle with learning standardized English.").

17. Dawn L. Smalls, *Linguistic Profiling and the Law*, 15 STAN. L. & POL'Y REV. 579, 582 (2004) (arguing that housing searches present "an ideal setting for linguistic profiling"); *see* Equal Housing Opportunity Flyer "Sounds like Discrimination" ("What matters is how you look on paper - not how you sound over the phone. Judging you by your national origin or race instead of your qualifications is discrimination. . . . The best way to stop housing discrimination is to report it.").

18. Smalls, *supra* note 17 at 580–81 (discussing the negative effects of linguistic and ethnic minorities having "non-standard dialects" within different employment contexts such as getting promotions); *see also* Mari J. Matsuda, *Voices of America: Accent, Antidiscrimination Law, and a Jurisprudence for the Last Reconstruction*, 100 YALE L.J. 1329, 1348–57 (1991) (analyzes incidents in Hawaii where speakers of Hawaiian Creole, Korean, and other languages were discriminated against in employment contexts based upon accents).

19. *See generally* Donna F. Coltharp, *Speaking the Language of Exclusion: How Equal Protection and Fundamental Rights Analyses Permit Language Discrimination (comment)*, 28 ST. MARY'S L.J. 149 (1996); *see generally* Christine Woo, *The Pervasive Problem of 'Linguistic Racism'*, BBC (June 3, 2021), https://www.bbc.com/worklife/article/20210528-the-pervasive-problem-of-linguistic-racism.

ing impacts. Some of these outcomes (i.e., being found guilty or innocent in a criminal proceeding) can be found to impact not only a person's life but also their families, friends, and the overall system. Since people generally know and interact with people of the same culture/race/ethnicity, the effects of linguistic discrimination are largely felt by insular minority groups.[20] The United States' legal system's emphasis on respecting precedent means that judges are obliged to make their rulings as consistent as reasonably possible with previous judicial decisions on the same subject. So, in this sense as well, the effects of interactions with the legal system mean so much to people who are found in similar situations decades later.

PART II of this note surveys the history of U.S. governmental interference in minority languages broadly and then situates African American Vernacular English (AAVE) within this history. PART III discusses linguistic based discrimination broadly speaking while PART IV offers a narrower look into how bias against AAVE in the criminal context, specifically where a black or AAVE-speaking person is a witness or suspect, can negatively harm those minority speakers. PART V analyzes potential solutions and offers ways to ensure that witnesses and victims are more protected from linguistic discrimination within the legal area. Finally, PART VI concludes the examination of language discrimination.

II. A HISTORICAL PERSPECTIVE: THE U.S. GOVERNMENT AND LANGUAGE ATTRITION

To be clear: the United States has no official language, nor has it ever had one in any of its history.[21] In this sense, the United States government acted differently than the Spanish[22] or English[23] rulers

20. According to the rationale of United States v. Carolene Products, 304 U.S. 144, 152–53 (1938), a group of minority language speakers are a classic example of a discrete and insular minority. People who speak a minority language lack the political power to sway any vote of the legislature. *See also* Smothers v. Benitez, 806 F. Supp. 299, 304–305 (D.P.R. 1992) (citing Carolene Products in a language discrimination case).

21. Annotation, *"English Only" Requirement for Conduct of Public Affairs*, 94 A.L.R.5th 537, 2 (2001) ("[T]he Federal Government has not recognized English as the official language of the United States under the Constitution or federal law."); *see also* Harmeet Kaur, *FYI: English Isn't the Official Language of the United States*, CNN (June 15, 2018, 2:27 PM ET), https://www.cnn.com/2018/05/20/us/english-us-official-language-trnd/index.html.

22. Barcelona is one of the best-known cities in the world, yet visitors ignorant of Spain's history with language attrition would be surprised to hear Catalan spoken in the streets. Catalan, which is a language spoken by people of Catalonia, which is a region in Spain that has a vibrant history as a once independent nation. Catalan has had a troubled history but is a key marker of identity in Catalonia. After the Spanish Civil War ended in 1939, the repression of

who did pass legislation limiting non-standard languages, Catalan and Welsh, respectively, in their countries' histories. When drafting the Constitution of the United States, the founding fathers likely intentionally left out naming a national language or any other pieces of restrictive legislation about language in order to avoid explicitly excluding anyone from the multi-ethnic, immigrant population that would become citizens of their new state.[24] Despite this reality, there is and has always been a very large "English Only" movement in the United States.[25]

Disputes between English-speaking U.S. citizens and immigrants over English have been waged since the 1750s when street signs in Pennsylvania were changed to include both English and German lan-

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Catalan was not only political but cultural too. Catalan institutions were suppressed, and Catalan was banned in the school system. Indicative of the new political order were statements from the authorities, the police in particular, such as "Hable el idioma del imperio": use the language of the empire. The immediate consequence was that Catalonia lost many of the material resources for the production and reproduction of its culture. The Catalan language lost prestige in comparison with Spanish, and some upper-class Catalans began to start speaking more Spanish. Vicente Rodriguez, *Catalonia*, BRITTANICA, https://www.britannica.com/place/Catalonia (last visited Feb. 11, 2022); Irene Boada, *How Catalan Survived: Branning a Language May Be an Effective Way of Preserving It*, THE ATLANTIC, (Sept. 26, 2015), https://www.theatlantic.com/international/archive/2015/09/catalan-spain-independence-vote/407446/; *see generally* Ferran Ferrer, *Languages, Minorities and Education in Spain: The Case of Catalonia*, 36 COMPARATIVE EDUC. 187 (2000) (discussing the modern trend of Catalan's re-emergence in Catalonia).

23. Welsh is potentially one of the oldest living languages in Europe. Despite its long existence, less than 30% of the Wales population can speak Welsh, and only 16% speak it daily. WELSH LANGUAGE DATA FROM THE ANNUAL POPULATION SURVEY: JULY 2019 TO JUNE 2020, GOV.WALES, 28 Dec 2020. After the English made its sovereignty over Wales official with Henry VIII's Act of Union in 1536, use of the Welsh language was largely banned. Laws were passed which removed the official status of the Welsh language and also extended into education, as schools were meant to conduct classes in English only. Poppy Jacob, *A Brief History of the Welsh Language*, CULTURE TRIP (July 29, 2017), https://theculturetrip.com/europe/united-kingdom/wales/articles/a-brief-history-of-the-welsh-language/. One report written by the English government in 1847, called the Reports of the Commissions of Inquiry into the State of Education in Wales, noted that the continued use of the "evil" Welsh language is one of the main causes of the Welsh people being "ignorant", "lazy" and "immoral." *See generally* GWYNETH TYSON ROBERTS, LANGUAGE OF THE BLUE BOOKS: WALES & COLONIAL PREJUDICE (1998).

24. While the Constitution does not explicitly name English as the official language of the United States, history supports the notion that government actors did try to impose it in the colonies. *See* James Crawford, *Bilingual Education Traces Its US Roots to the Colonial Era,* EDUC. WK., (Apr. 1, 1987), https://www.edweek.org/teaching-learning/bilingual-education-traces-its-u-s-roots-to-the-colonial-era/1987/04 (explaining that the U.S. government imposed English on new colonies Puerto Rico and the Phillipines following its victory in the Spanish-American war).

25. René Galindo & Jami Vigil, *Language Restrictionism Revisited: The Case Against Colorado's 2000 Anti-Bilingual Education Initiative*, 7 HARV. LATINO L. REV. 27, 46 (2004) ("English immersion initiatives are merely one part of a larger English-only movement that has grown out of a long history of domestic language restrictionism."); *see also* Juan F. Perea, *Demography and Distrust: An Essay on American Languages, Cultural Pluralism, and Official English*, 77 MINN. L. REV. 269 (1992) (analyzing the English-only movement beginning with a discussion of the Federalist Papers and continuing through the present).

guages to accommodate the many German immigrants.[26] This German-English debate continued until World War I, when international hostility resulted in the rejection of all things German, including the prohibition of the German language and German-language materials, particularly books.[27] While this prohibition held serious consequences to German-speaking people, there is no legislation that was as far reaching as legislation geared towards indigenous peoples and those enslaved.

To support this notion, scholars created a new term, "cultural genocide," to describe the efforts of the Canadian government to assimilate indigenous people.[28] The Canadian government tried to assimilate Indigenous people through residential schools and other related policies leading scholars to conclude that the assimilation was intended to destroy the Indigenous Peoples of Canada as a culturally distinct group.[29] The last of these residential schools in Canada was closed in 1996—much more recently than one would think.[30] There were many rules and limitations placed on indigenous children in these schools to assimilate them as well as rampant abuse and neglect of the indigenous children within them.[31] One of these prohibitions was not allowing the students to speak in their native tongue with each other.[32] When analyzing comparable actions by the United States government, it becomes clear that policies centered around limiting the use of language can be detrimental to non-majority groups.

The first example I will note begins in the early 1900s here in the United States, where similar efforts to "kill the Indian, save the man" were occurring.[33] These policies essentially took indigenous children

26. Peter Gilmore, *Pennsylvania's Official Language*, POST GAZETTE (Oct. 30, 2011, 12:00 AM), https://www.post-gazette.com/opinion/Op-Ed/2011/10/30/Pennsylvania-s-official-language/stories/201110300169.

27. *Id.*

28. *Cultural Genocide: Stolen Lives – The Indigenous Peoples of Canada and the Indian Residential Schools*, FACING HIST. & OURSELVES, https://www.facinghistory.org/stolen-lives-indigenous-peoples-canada-and-indian-residential-schools/chapter-7/cultural-genocide (last visited Feb. 10, 2022).

29. *Id.*

30. Zinaida Miller, *The Injustices of Time: Rights, Race, Redistribution, and Responsibility*, 52 COLUM. HUM. RIGHTS L. REV. 647, 704 (2021).

31. *Id.* at 708–09 ("[T]he schools suppressed Indigenous languages and cultures; imposed strict discipline for infractions that included using one's native language; institutionalized child neglect; and were so poorly staffed that students were 'prey to sexual and physical abusers.' Moreover, by creating the residential school system, the government 'essentially declared Aboriginal people to be unfit parents.'") (internal citations omitted).

32. *Id.*

33. "Kill the Indian, Save the man" was a movement geared towards assimilating Native peoples in early United States History. The movements name is coined from a speech delivered

from their families and forced them to go to boarding schools where they were beaten if they spoke their first language.[34] English was the only language that was allowed in these boarding schools.[35] These schools created a generation of indigenous people that were unable to natively speak their mother tongue since children were unable to practice it.

African Americans also have an especially horrible history in relation to language in the United States. As is well known, most African Americans are descendants of the diverse peoples who were captured in Africa by slave traders and transported to the Western hemisphere.[36] After slavery officially ended, the systems of chattel slavery and the Jim Crow segregation era were carefully designed to keep African Americans in subordinate positions in the United States.[37] After those systems were officially disbanded the cultural oppression that took place is still felt in the status quo by Black people in America.[38] But, the efforts taken by the United States during the slave era were the start of a very destructive system of cultural decimation.

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by Captain Richard H. Pratt, a military officer, in 1892 regarding the education of indigenous people. The movement can be summarized by this excerpt from his speech, "It is a great mistake to think that the Indian is born an inevitable savage. He is born a blank, like all the rest of us. Left in the surroundings of savagery, he grows to possess a savage language, superstition, and life. We, left in the surroundings of civilization, grow to possess a civilized language, life, and purpose. Transfer the infant white to the savage surroundings, he will grow to possess a savage language, superstition, and habit. Transfer the savage-born infant to the surroundings of civilization, and he will grow to possess a civilized language and habit." The movement called for "killing" the aspects of Native identity that the majority culture deemed "savage" which included their language. RELIGIOUS INTOLERANCE IN AMERICA: A DOCUMENTARY HISTORY 140–41 (John Corrigan & Lynn S. Neal eds., 2010).

34. *Id.*; Wilbert H. Ahern, *An Experiment Aborted: Returned Indian Students in the Indian School Service*, *1881-1908*, 44 ETHNOHISTORY 263 (1997).

35. Jennifer Jones, Dee Ann Bosworth & Amy Lonetree, *American Indian Boarding Schools: An Exploration of Global Ethnic & Cultural Cleansing*, ZIIBIWING CENTER OF ANISHINABE CULTURE & LIFEWAYS, http://www.sagchip.org/ziibiwing/planyourvisit/pdf/aibscurrguide.pdf. (last visited Feb. 10, 2022) (describing Captain Pratt's "social experiment" on Apache prisoners of war at the Carlisle Indian Industrial School where he forced them to use English, cut their long hair, made them wear uniforms, and made them adhere to strict military protocols).

36. Sarah Pruitt, *What Part of Africa Did Most Enslaved People Come From?,* HISTORY.COM (June 19, 2019), https://www.history.com/news/what-part-of-africa-did-most-slaves-come-from (explaining that of the 388,000 enslaved Africans brought to the United States prior to the end of the slave trade, "nearly half [of them] came from two regions: Senegambia. . . today's Senegal, Gambia, Guinea-Bissau and Mali; and west-central Africa, including what is now Angola, Congo, the Democratic Republic of Congo and Gabon.")

37. *See generally From Slavery to Segregation*, SEGREGATION IN AMERICA, https://segregationinamerica.eji.org/report/from-slavery-to-segregation.html (last visited Feb. 10, 2022).

38. *Id.*

During the slave era in the United States, African slaves who spoke the same languages native to their home countries were intentionally separated upon sale to ensure that they could not hold onto their native culture and could not communicate to conspire for freedom.[39] Partly as a result, the slave codes of the Old South made learning written English a crime for slaves, and teaching literacy to slaves was a crime for all southerners, Black or white.[40] Not only were the slaves prevented from mastering the dominant language of their new land, but they were also typically punished severely for speaking African languages, practicing their native religions, or following other cultural traditions of their ancestors.[41]

With this historical context in mind, currently, AAVE speakers are susceptible to facing linguistic-based discrimination even though AAVE is rarely thought of as a dialect different than Standard American English (SAE). AAVE is mostly spoken by working African Americans in urban environments,[42] and is largely classified by a subgroup of non-speakers as "ghetto" or a version of "bad English." But unknown to many people, this characterization is false since AAVE *has* in fact been described as a full-fledged dialect of English.[43]

Even though the words "dialect" and "language" are used to describe seemingly different things, there is no objective difference or technical distinction between the two.[44] In fact, any attempt made to try to impose rigid definitions on these concepts falls apart. The most

39. DeNeen L. Brown, *'Barbaric': America's Cruel History of Separating Children from Their Parents*, WASH. POST (May 31, 2018), https://www.washingtonpost.com/news/retropolis/wp/2018/05/31/barbaric-americas-cruel-history-of-separating-children-from-their-parents/.

40. *See generally Literacy and Anti-Literacy Laws*, ENCYCLOPEDIA.COM, https://www.encyclopedia.com/humanities/applied-and-social-sciences-magazines/literacy-and-anti-literacy-laws (last visited Mar. 9, 2022).

41. *Id.* ("Virginia slave codes. . . . required that 'any slave or free person of color found at any school for teaching, reading or writing by day or night' could be whipped, at the discretion of a judge, 'no more than twenty lashes.' Any white person found teaching "free coloured persons or slaves" to read could be fined between $10 and $100 and serve up to two months in jail. Mississippi state law required a white person to serve up to a year in prison as "penalty for teaching a slave to read").

42. Clifton B. Parker, *Neighborhoods Influence Use of African American Vernacular English, Stanford Research Shows*, STAN. NEWS (Sept. 10, 2015) https://news.stanford.edu/2015/09/10/vernacular-language-rickford-091015/.

43. Patt Morrison, *Patt Morrison Asks: Stanford Linguistics Professor John Rickford on the Legacy of Ebonics*, L.A. TIMES (Aug. 24, 2016), http://www.latimes.com/opinion/op-ed/la-oe-patt-morrison-asks-john-rickford-20160823-snap-story.html (arguing that AAVE speaking children as "bi-dialectal" meaning they can fluently speak and understand more than one dialect, one of them being AAVE).

44. Katharina Gruber, *Language Versus Dialect: Understanding the Difference*, BARE BONES TRANSLATIONS (May 23, 2020), https://www.barebones-translations.com/post/language-versus-dialect-understanding-the-difference.

common separation tactic with English at least is based on "intelligibility."[45] This principle posits that if a native speaker can understand speech without training, then that speech is a dialect of their own language, but, if they cannot understand then the speech belongs to a separate language.[46] But even this intelligibility rule is not a steadfast one.[47]

In academia, the difference between a dialect and a language is captured in this common quote among linguists by Max Weinreich: "a language is a dialect with an army and a navy."[48] Popular usage of the terms "language" and "dialect" impose more of a difference between the two with the suggestion that languages are standardized, can be written and thus have literature, while dialects are oral without codified rules of usage, and have no literature.[49] When colloquially used, there's also an underlying implication that there is something lesser about a dialect.[50] A dialect, as defined by the American Heritage Dictionary, is, "a regional variety of language distinguished by pronunciation, grammar, or vocabulary, esp. a variety of speech differing from the standard literacy language or speech pattern of the culture in which it exists."[51] Despite this lack of a standard definition in academia, AAVE is largely considered a dialect of English that only a subset of English speakers can understand and speak themselves. AAVE is a dialect because it is a variation of Standard American English (SAE).

AAVE has also been described as a language.[52] Even though I refer to it as a dialect throughout this comment, the political ramifica-

45. *Id.*; John McWhorter, What'*s a Language, Anyway?*, THEATLANTIC.COM (Jan 19, 2016), https://www.theatlantic.com/international/archive/2016/01/difference-between-language-dialect/424704/.

46. Gruber, *supra* note 44.

47. *Id.*; McWhorter, *supra* note 45.

48. Jill Gaulding, *Against Common Sense: Why Title VII Should Protect Speakers of Black English*, 31 U. MICH. J.L. REFORM 637, 656, 706 (1998) ("'Max Weinreich is widely quoted as pointing out that a language is a dialect with an army and a navy; I would like to add to that observation that a dialect is perhaps nothing more than a language that gets no respect.'") (quoting ROSINA LIPPI-GREEN, ENGLISH WITH AN ACCENT: LANGUAGE, IDEOLOGY, AND DISCRIMINATION IN THE UNITED STATES (1997)).

49. McWhorter, *supra* note 45.

50. *Id.*

51. Dialect, AM. HERITAGE DICTIONARY, https://www.ahdictionary.com/word/search.html?q=dialect (last visited Mar. 9, 2022).

52. *See generally* Taneesh Khera, *What Makes African American Vernacular English Distinct and Complex*, DICTIONARY.COM (Feb. 21, 2022) ("defining AAVE as either a dialect of English, or a separate language altogether, depends on how you believe it began."); *see generally Hooked on Ebonics*, PBS (Jan 4, 1997); *see generally* Renée Blake & Kimberley Baxter, *10 Things to Know About African American Language*, MENTAL FLOSS (Jan. 25, 2021) ("African

tions of these classifications must be explored. The difference in characterizing AAVE as a language versus a dialect arguably stems from the historically-created asymmetry of political and social power that African Americans have held relative to white Americans.[53] Many linguistic theorists make convincing arguments that the association of Standard American English as the "correct" and "proper" version of English is a result of the unbalanced power and wealth distribution in America.[54] According to world-renowned linguist Noam Chomsky, "If the distribution of power and wealth were to shift from southern Manhattan to East Oakland, 'Ebonics' would be the prestige variety of English and [those on Wall Street] would be denounced by the language police."[55] Chomsky illustrates the relationship between power and language control. For centuries, white Americans have had exclusive ownership over the institutions that produce social norms. White Americans have controlled the job market as employers,[56] have controlled governmental policy over English education, and have owned national media and entertainment outlets.[57] With such power, traits and characteristics associated with white Americans were instilled as the normatively correct versions. As a consequence, AAVE was dis-

American English (AAE) is a systematic and complete language that operates under a set of rules. . .").

53. Michael T. Purcell, *Access to Justice Proper Use of Interpreters and Translators*, OR. ST. B. BULL., June 2015, at 24, 25 ("What is a "dialect" and what is a "language" is often a political question."); *see also* Julian S. Lim, *Tongue-Tied in the Market: The Relevance of Contract Law to Racial-Language Minorities*, 91 CAL. L. REV. 579, 598 (2003) (explaining that while "the use and promotion of the English language can be self-affirming for members of the dominant culture, the coercive nature of sanctioning and reinforcing only the language and ethnic traits of the dominant culture to the exclusion of different, but equally American, languages results in great inequality.").

54. John R. Rickford, *LSA Resolution on the Oakland "Ebonics" Issue*, LINGUISTICS SOC'Y AM. (Mar. 19, 1997) (quoting from a resolution unanimously adopted at the annual meeting of the Linguistic Society of America in Chicago, Illinois, on Jan. 3, 1997: "The distinction between 'languages' and 'dialects' is usually made more on social and political grounds than on purely linguistic ones. For example, different varieties of Chinese are popularly regarded as dialects, though their speakers cannot understand each other, but speakers of Swedish and Norwegian, which are regarded as separate languages, generally understand each other.").

55. Neil Chaudhary, *Cultural Domination in Language: Why You Talk Like That?*, STAN. DAILY (May 14, 2015, 9:43 p.m.), https://www.stanforddaily.com/2015/05/14/cultural-domination-in-language-why-you-talk-like-that/.

56. Andrew Soergel, *Most of America's Businesses Run by White Men*, U.S. NEWS, (Sept. 1, 2016, 12:12 PM), https://www.usnews.com/news/articles/2016-09-01/most-of-americas-businesses-run-by-white-men-says-census-bureau.

57. John W. Schoen & Yelena Dzhanova, *These Two Charts Show the Lack of Diversity in the House and Senate*, CNBC, (Jun 2, 2020, 2:28 PM), https://www.cnbc.com/2020/06/02/these-two-graphics-show-the-lack-of-diversity-in-the-house-and-senate.html; *Diversity in Media Ownership*, FREE PRESS, https://www.freepress.net/issues/media-control/diversity-media-ownership (last visited Feb. 10, 2022).

regarded as inappropriate for mainstream American society, resulting in the outrage over events such as the Oakland board resolution.[58]

In 1996 the Oakland Unified School District (the school board) passed a resolution acknowledging the legitimacy of "ebonics" by incorporating it into school systems.[59] The board's goal was to create "environments where . . . African-American pupils shall not, because of their race, be subtly dehumanized" through "maintaining the legitimacy and richness of [their] language."[60] The two-page resolution garnered critique from, amongst other people and entities, The New York Times editorial page,[61] Reverend Jesse Jackson,[62] and even then-President Clinton's Secretary of Education Richard Riley.[63] After receiving media attention from such large names, the resolution immediately erupted into a national controversy questioning the legitimacy of Ebonics as a real language.[64] Mainstream media interpreted the actions of the Oakland School Board as an attempt to gain bilingual funding from the state and federal government and seemed to treat AAVE as merely as an accent or slang.[65] The media was willing to acknowledge a Standard English, the English spoken by the white American majority. The media's response was another attempt to establish that standard American English is the "correct version" because it is considered respectful and proper. However, the cost of establishing a "standard" English should have been considered too high because it necessitates the marginalization of other English dia-

58. Tim Golden, *Oakland Scratches Plan to Teach Black English*, N.Y. TIMES (Jan. 14, 1997), https://www.nytimes.com/1997/01/14/us/oakland-scratches-plan-to-teach-black-english.html#:~:text=hoping%20to%20quell%20the%20uproar,ebonics%2C%20school%20officials%20said%20today.

59. Chaudhary, *supra* note 55.

60. *See id.;* Golden, *supra* note 58.

61. *See generally* Jesse McKinley, *Board's Decision on Black English Stirs Debate*, N.Y. TIMES (Dec. 21, 1996), https://archive.nytimes.com/www.nytimes.com/library/national/1221calif-black-english.html; *Black English Plan Baffles Some Students in Oakland*, N.Y. TIMES (Dec. 21, 1996), https://www.nytimes.com/1996/12/21/us/black-english-plan-baffles-some-students-in-oakland.html.

62. Martha Irvine, *Jesse Jackson Takes Back Criticism of Oakland School 'Black English' Plan*, AP NEWS (Dec. 27, 1996), https://apnews.com/article/1631c794b74a843fa6d07d27fdbb8e7e ("Last week, Jackson harshly criticized the Oakland school board's decision to recognize [B]lack English, saying the district shouldn't be teaching students to 'talk garbage.'").

63. John F. Harris, *U.S. Bilingual Education Funds Ruled Out for Ebonics Speakers*, WASH. POST (Dec. 25, 1996) https://www.washingtonpost.com/archive/politics/1996/12/25/us-bilingual-education-funds-ruled-out-for-ebonics-speakers/6382e7bc-eca4-4ee6-aff1-0086438ff3ba/ (quoting Secretary of Education Riley Richard stating, "The administration's policy is that Ebonics' is a nonstandard form of English and not a foreign language.").

64. Alexander Russo, *Lessons from the Media's Coverage of the 1996 Ebonics Controversy*, KAPPA ONLINE (Mar. 21, 2018), https://kappanonline.org/russo-ebonics-coverage-65649-2/.

65. *Id.*

lects. That means that other varieties of English, largely spoken by minorities in America, are devalued as something criminal, uneducated, and associated with otherwise unpleasant qualities. Regardless of if AAVE is classified as a language, dialect, or an accent, its speakers are still deserving of the respect of SAE speakers and are undeserving of the negative stereotypes associated with it.

One of the common misconceptions that leads to thoughts of AAVE as inferior to SAE, is that AAVE is SAE with grammatical mistakes and a different, less formal, vocabulary. This is just simply untrue. If lawmakers, educators, and other important societal actors recognized that AAVE is just as legitimate as SAE then maybe it would not be so hard to think of AAVE speakers as speaking a different type of legitimate English. AAVE is a rule-based, complex, and expressive system of communication — in fact, AAVE strategically simplifies and complicates some of the grammatical structures in SAE in ways that are more efficient. If all of this is true, AAVE is more than a badly constructed version of SAE or street slang.

One of the grammatical distinctions between AAVE and SAE that would make AAVE "more complicated" so to speak is that there is a "remote present perfect" tense in AAVE that does not exist in SAE.[66] In other words, there is another way to conjugate verbs that would violate the rules of SAE. Take the AAVE sentence, "she *been* tired." The *been* in that sentence does not just mean that "she has been tired" but it can also mean that she has been in a state of tiredness for a long while. An AAVE speaker can express the same expression in fewer syllables, arguably a good thing in terms of efficiency. Another verb tense that exists in AAVE but not in SAE is the "habitual be."[67] This verb form is used to indicate a habitual or repeatable action. The term "habitual be" is said to derive from the fact that the verb "to be" does not change its form to reflect the present or past tense, or to agree with the subject of the sentence.[68] Take another AAVE sentence, "Molly *be* walkin' the dog." To an SAE speaker, translating this directly would bring them to conclude that "Molly is walking the dog." However, to another AAVE speaker,

66. Candace L. Scott, *Tense & Aspect Markers in African American English*, at 120 (2016) (Ph.D. dissertation, The University of Michigan) (Online at University of Michigan's Library Deep Blue Documents Repository).

67. Raffaella Zanuttini & Katie Martin, *Invariant* Be, YALE GRAMMATICAL DIVERSITY PROJECT: ENGLISH IN N. AM., https://ygdp.yale.edu/phenomena/invariant-be (last visited Mar. 9, 2022).

68. *Id.*

they would understand that the original speaker's message is really that Molly customarily walks, or is in the habit of walking, her dog. It does not necessarily mean that Molly is outside at that very moment walking her dog.

Researchers in a 2005 University of Massachusetts study demonstrated the existence of the Habitual Be in AAVE with a now very famous experiment amongst children. In this study, researchers showed a group of white and Black children images from *Sesame Street*.[69] The most relevant image for this discussion was an image of a sick, bed-ridden Cookie Monster next to a seemingly healthy Elmo who was eating cookies.[70] When researchers asked the test subjects, "Who is eating cookies?" all the children indicated Elmo.[71] When the question was changed to, "Who be eating cookies?" The white children replied that it was Elmo, and the Black ones indicated Cookie Monster.[72] This makes perfect sense considering Cookie Monster's state of being calls for him to usually eat cookies. To an AAVE speaker, Cookie Monster be eating cookies regardless of if he is eating cookies in the moment or not.

Both the remote present perfect tense and habitual be exist in other dialects and languages. In terms of the remote present perfect tense, researchers have found that it is used in conservative English dialects such as Newfoundland English.[73] Many more languages employ the "Habitual Be," including but not limited to Gaelic,[74] Caribbean English, Newfoundland English, and Hiberno English, which is typically heard in Ireland.[75] The presence of these grammatical structures in other varieties of English should dissuade most people of the notion that AAVE is a collection of inconsistently applied or random bits of Standard American English. Rather it is grounded in rules and grammar that exist outside of the confines of SAE, which means that it has to be at least equal in terms of its legitimacy.

69. Katy Waldman, *Why We Be Loving the "Habitual Be"*, SLATE (June 5, 2015, 10:57 AM), https://slate.com/human-interest/2015/06/the-habitual-be-why-cookie-monster-be-eating-cookies-whether-he-is-eating-cookies-or-not.html (citing Janice E. Jackson & Lisa Green's book chapter, *Tense and Aspectual be in African American English* in Perspectives on Aspect 233-250 (Henk J. Verkuyl et al. eds., 2005)).

70. *Id.*

71. *Id.*

72. *Id.*

73. Scott, *supra* note 66, at 120.

74. Waldman, *supra* note 69.

75. Zanuttini & Martin, *supra* note 69.

III. LINGUISTIC PROFILING BROADLY

Linguistic discrimination (also called linguicism or linguistic profiling) is the unfair treatment of an individual based solely on his or her use of language.[76] This use of language may include the individual's native language or other characteristics of the person's speech, such as an accent; the size of vocabulary (whether the person uses complex and varied words); modality;[77] and syntax.[78] Based on a difference in use of language, a person may automatically form judgments about another person's wealth, education, social status, character, or other traits. These perceived judgments may then lead to the unjustifiable mistreatment of the individual.

The first documented study regarding this unjustifiable mistreatment based on language was by John Baugh, a linguist at Washington University in St. Louis.[79] He was the first to document the "linguistic profiling" some minorities face over the phone.[80] It started in the late 1980s when Baugh, who is Black, said he was discriminated against while searching for apartments in Palo Alto, California, where he was living as a fellow at Stanford University.[81] Baugh launched an experiment in which he made hundreds of phone calls to landlords who had listed apartments in the San Francisco area, employers, real estate agents, loan officers and service providers.[82] He greeted each landlord with the same line: "Hello, I'm calling about the apartment you have advertised in the paper."[83] But he didn't always say it in the same accent — he alternated between using an "African-American accent," which I took to mean he was speaking AAVE, a Mexican-American accent, and his natural accent, what he called "professional standard English."[84] He found that in white areas, landlords were far

76. *See* Patricia Rice, *Linguistic Profiling: The Sound of Your Voice May Determine if You Get that Apartment or Not*, THE SOURCE (Feb. 2, 2006), https://source.wustl.edu/2006/02/linguistic-profiling-the-sound-of-your-voice-may-determine-if-you-get-that-apartment-or-not/.

77. "Modality" in terms of linguistic meaning deals with the speaker's expression of possibility and/or necessity. Low modality shows less certainty, obligation, probability of occurring, whereas high modality shows a high degree of these. *See* Kai von Fintel, *Modality and Language*, ENCYCLOPEDIA.COM (last visited February 11, 2022).

78. Rice, *supra* note 76.

79. Smalls, *supra* note 17, at 582; *see also* Rice, *supra* note 76.

80. Rice, supra note 76.

81. Smalls, *supra* note 17, at 582; *see also Using Linguistics to Fight Housing Discrimination*, STAN. MAG. (Jan./Feb. 2003), https://stanfordmag.org/contents/using-linguistics-to-fight-housing-discrimination.

82. Rice, *supra* note 76.

83. STAN. MAG, *supra* note 81.

84. *Id.*

less responsive to him when he spoke in AAVE or in a Latino accent.[85] In one predominantly white community, Baugh found that he was offered a chance to tour an apartment seventy percent of the time when he used his standard-English voice, but less than thirty percent when he spoke in a Latino or Black accent and/or dialect.[86] Baugh's research demonstrated that racism extends further than just face-to-face interactions since the manner of speech was the only factor that could have created the different outcome.

IV. LINGUISTIC PROFILING WITHIN THE CRIMINAL LAW CONTEXT

While Baugh began studying linguistic profiling in the realm of housing, the prevalence of linguistic based discrimination in the criminal context is the focus of this note. One shape that this form of discrimination takes is in identifying suspects. Witnesses are regularly allowed to testify to the race of the speaker based solely on the linguistic inferences gathered from the speaker's speech, without additional identifying information. Case law includes cursory references to testimony offered by witnesses that testify that a perpetrator "sounded black" or "sounded white."[87] One controversial case in particular highlights this dilemma.

In *Clifford v. Commonwealth of Kentucky*, the defendant, a Black man, was convicted of trafficking illegal substances after being identified by his voice as sounding like a Black man's.[88] A local police officer, Detective Birkenhauer, asked an informant, a white man to help set up a sting operation by coordinating a meeting between Detective Birkenhauer and Clifford, the defendant, for the detective to buy co-

85. *Id.*

86. Marl Abadi, *'Sorry to Bother You' Is Right — Minorities Are Judged by the Sound of Their Voice, and There's Science to Prove It*, BUS. INSIDER (Jul. 8, 2018, 6:47 PM), https://www.businessinsider.com/sorry-to-bother-you-language-discrimination-2018-6.

87. People v. Sanchez, 492 N.Y.S.2d 683, 684-85 (N.Y. Sup. Ct. 1985) (allowing a lay eyewitness to a fatal shooting to testify that immediately prior to the shooting, he overheard the victim and the killer arguing in Spanish, and that the killer was speaking with a Dominican, rather than a Puerto Rican, accent); Rhea v. State, 147 S.W. 463, 471 (Ark. 1912) (holding that a witness may recognize and know the difference between voices of persons of different nationalities and races); State v. McDaniel, 392 S.W.2d 310, 315 (Mo. 1965) (allowing testimony that robbers had African American accents to identify the likely race of the perpetrators); State v. Smith, 415 S.E.2d 409, 415 (S.C. Ct. App. 1992) (admitting testimony of radio dispatcher describing the caller as a white male, approximately forty years old, with a "very country and rugged, scratchy like voice"); State v. Kinard, 696 P.2d 603, 604 (Wash. Ct. App. 1985) (holding testimony that one burglar "sounded [B]lack to me" to a robbery victim and another sounded like a young white male, was properly admitted).

88. Clifford v. Ky., 7 S.W.3d 371, 373, 376 (Ky. 1999).

caine from Clifford.[89] At the meeting, Detective Birkenhauer saw the white informant, a female friend of the informant, and later, Clifford emerged from a different room in the apartment.[90] After telling Clifford how much cocaine he wanted, Clifford and the white informant went into a back room, Clifford later emerged from the room with the informant holding the cocaine that went to Detective Birkenhauer.[91] It is critical to emphasize that it was the informant and not Clifford who came out of the bedroom with the drugs.[92] At trial, Clifford did not testify but the informant testified that the crack cocaine actually belonged to him and not Clifford, that Clifford was not involved in the transaction, and did not make the sale to Detective Birkenhauer.[93]

Unbeknownst to Clifford, another officer, Officer Smith, was monitoring the sting operation via a wire.[94] The actual audio recording was not played in court, but the court allowed Officer Smith to testify that he heard four different voices: Detective Birkenhauer's, another male, a female, and a fourth voice which "sounded as if it was of a [Black man]."[95] Officer Smith explained that his experience of being a police officer for thirteen years that had spoken to Black males on numerous occasions, was why he believed he could testify that the last voice which he heard was that of a Black male.[96] Clifford was found guilty of trafficking in a controlled substance and subsequently sentenced to twenty years in prison for being a persistent felony offender.[97] On appeal, Clifford argued that Officer Smith should not have been able to say that he thought the fourth voice sounded like a Black man, but the court did not agree.[98] The court reasoned that Officer Smith identified one of the voices as female with little pushback, so it stands to reason that he can do the same in regards to race and/or nationality.[99] Justice Stumbo penned the dissent and aptly

89. *Id.* at 373.
90. *Id.*
91. *Id.*
92. *Id.*
93. *Id.*
94. *Id.*
95. *Id.*
96. *Id.*
97. *Id.*
98. *Id.* at 373–74.
99. *Id.* at 375–76 ("No one suggests that it was improper for Officer Smith to identify one of the voices he heard as being that of a female. We perceive no reason why a witness could not likewise identify a voice as being that of a particular race or nationality, so long as the witness is personally familiar with the general characteristics, accents, or speech patterns of the race or nationality in question, i.e., so long as the opinion is 'rationally based on the perception of the witness.'") (internal citation omitted).

concluded that there is no rational relation between appearance and accent and/or language and that Officer Smith's testimony was very prejudicial considering Clifford was the only Black man at the defense table.[100]

Contrast *Clifford* with *Doe,* where the United States Court of Appeals for the District of Columbia Circuit excluded testimony of a Detective that aimed to identify Jamaican defendants as Jamaican drug dealers because of their Jamaican accent.[101] In reaching this holding, the court applied Federal Evidence Rule 403 which states that relevant evidence may be excluded "if its probative value is substantially outweighed by the danger of unfair prejudice."[102] Other jurisdictions have also used Federal Evidence Rule 403 to exclude identification based on voice alone because of the risk of prejudicial effect.[103] By allowing Officer Smith to testify, *Clifford*, and the cases in line with its holding, confer legal legitimacy on linguistic stereotyping. There is clearly an avenue for judges to step in and protect minority speakers in the context of suspect identification — courts are just electing to not exercise this protection.

Turning back to Rachel Jeantel's testimony, her experience in the historically significant Trayvon Martin case represents the reality for many AAVE speakers that encounter the legal system. She was not supposed to be on trial, but somehow that is what ended up happening. People like her, that is witnesses or defendants that speak in non-SAE English dialects, are more likely to be discredited and misunderstood in court rooms which can potentially lead to unfair legal outcomes.[104] In terms of Jeantel, she was fundamentally misunderstood and discredited because jury members, and the broader public, directed their lingual based prejudices toward her, and thus unfairly insulted, tested, and questioned her intelligence and credibility as a witness.[105]

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100. *Id.* at 377–79.

101. *See* United States v. Doe, 903 F.2d 16, 20 (D.C. Cir. 1990).

102. *Id.* at 21.

103. *See* United States v. Vue, 13 F.3d 1206, 1213 (8th Cir. 1994) (holding that "[B]ecause the injection of ethnicity into the trial clearly invited the jury to put the Vues' racial and cultural background into the balance in determining their guilt. We view this as a serious trespass on the rights to due process and equal protection guaranteed to the Vues by the fifth amendment.").

104. Rickford & King, *supra* note 1, at 949–50.

105. *See generally id.*; *see also* John McWhorter, Rachel Jeantel Explained, Linguistically, IDEAS TIME (June 28, 2013), https://ideas.time.com/2013/06/28/rachel-jeantel-explained-linguistically/

On February 26, 2012, the day her seventeen-year old friend Trayvon Martin was shot and killed by George Zimmerman, Jeantel was eighteen.[106] She lived in a city where many varieties of Caribbean English vernaculars were spoken which contributed to her variety of speech.[107] She has been classified as a fluent AAVE, English, Spanish, and Haitian Creole speaker by linguists which informs why and how she was speaking on the witness stand.[108] On this particular day she had a phone conversation with Martin as he was being profiled and followed by Zimmerman at the gated Retreat at Twin Lakes in Sanford, Florida.[109] Zimmerman was acting as a volunteer neighborhood watch coordinator at that gated community when the shooting occurred.[110] Jeantel's testimony was so pivotal because she was on the phone with Martin until minutes before his death, and thus, heard a lot of what was happening.[111] It is crucially important to note the context that surrounded her testimony — she was the key witness because she was able to directly contradict much of Zimmerman's defense.[112] For instance, she stressed the fact that Martin was moving away from Zimmerman and not towards him.[113]

At trial and during depositions, Jeantel was quoted and recorded using several common grammatical features of AAVE.[114] She used the habitual be, for instance, she stated, "that's where his headset be at," and remote present perfect to communicate that she knew prior to the deposition that she was the last person to speak to Trayvon Martin, "I been knew I was the last person to talk to Trayvon."[115] There were moments at trial that jurors and attorneys alike seemed confused by Jeantel's testimony, evidenced by their asking for clarification.[116]

While the testimony itself is important, this Note focuses mostly on the reactions to her testimony both within and outside of the courtroom. After the Zimmerman trial concluded with a not guilty verdict, jurors spoke on their thoughts during the case. One juror in particu-

106. Rickford & King, *supra* note 1, at 959–50 n.5.
107. *Id.* at 957.
108. *Id.*
109. *Id.* at 949–50 n.5.
110. *Id.*
111. *Id.* at 950.
112. *Id.* at 955.
113. *Id.*
114. *Id.* at 957.
115. *Id.* at 958.
116. *Id.* at 956, 972.

lar, B37, participated in an interview with CNN's Anderson Cooper in 2013.[117] During the interview the juror plainly stated that Jeantel was not credible or intelligible, and further, that she was "not a good witness."[118] Further, the juror implied that Jeantel's "education and communication skills" were subpar more than once.[119]

Outside of the courtroom, legal commentators and social media users also seemed to cast harsh judgments on Rachel's intelligence and credibility.[120] On social media, users did not hold back their thoughts. In fact, #RachelJeantel was trending on Twitter during the trial due to so many commenters reacting.[121] According to social media users, Jeantel's supposed lack of "intelligence" is what made it hard for her to be understood by the jury and greater population. According to Jeantel, it was her underbite that made it hard for people to understand her.[122] There is even evidence that she was misunderstood simply because she was speaking too softly in a larger-than-average courtroom.[123] Rachel demonstrates how AAVE speaking witnesses, many of whom testify on behalf of an AAVE speaker, can be maligned. But Demesme's experience demonstrates another horrible, yet common event, the actual accused being maligned because of their speech.

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117. Interview between CNN's Anderson Cooper and Juror B37 (June 2013) (tape from CNN's "Anderson Cooper 360") (Juror B37 said Jeantel was not a good witness because the phrases used during her testimony were terms she had never heard before. The juror thought the witness, "felt inadequate toward everyone because of her education and her communication skills. I just felt sadness for her.").

118. *Id.*

119. *Id.*

120. Rickford & King, *supra* note 1, at 957 (internal citations omitted)

> "She is a dullard, an idiot, an individual who can barely speak in coherent sentences"
> – Jim Heron, Appalachian State.
>
> "Sorry, but this is the blather of an idiot"
> – Thomas Stratford
>
> "[Rachel Jeantel] cannot even speak English. . . she speaks Haitian hood rat. . ."
> – edteach

Other examples include:

"The real travesty is how Rachel Jeantel murdered the English language. #NoJustice." US Army Lawn Dart (@USArmyLawnDart), TWITTER (July 14, 2013, 11:48 AM), https://twitter.com/usarmylawndart/status/356439992995811329?s=12.

"I pray that my nieces & nephew all grow up to better smart individuals not slow minded like tht hoe Rachel Jeantel!" Dr. Duval (@DrDuval904), TWITTER (June 264, 2013, 5:38 PM), https://twitter.com/DrDuval904/status/350005261609611264.

121. Shereen Marisol Meraji, *What [BLANK] Folks Don't Understand About Rachel Jeantel*, NPR (June 29, 2013, 7:00 AM), https://www.npr.org/sections/codeswitch/2013/06/29/196709577/what-blank-folks-dont-understand-about-rachel-jeantel.

122. Rickford & King, *supra* note 1, at 974–75.

123. *Id.*

A few years after Jeantel's testimony, Warren Demesme dealt with language-based discrimination by New Orleans police officers. In 2015, Demesme, then twenty-two, was accused of sexual assault by two young girls.[124] Subsequently, he was interrogated by New Orleans police officers twice.[125] At some point during the second interrogation, Demesme stated, "This is how I feel, if y'all think I did it, I know that I didn't do it so why don't you just give me a lawyer dog 'cause this is not what's up."[126] This punctuation in the record, of not including a comma between the word "dog" and "'cause," was provided in a brief by the Orleans Parish District Attorney's office.[127] The police officers conducting the interrogation failed to respond to Demesme's invocation of counsel and continued questioning him.[128] Demesme later admitted to the crime and was charged with aggravated rape and indecent behavior with a juvenile.[129]

According to the Washington Post, public defender Derwyn Bunton filed a motion to suppress Demesme's incriminating statement arguing that the police were required by law to stop questioning Demesme when he asked for a lawyer.[130] This motion to suppress was eventually filed with the Louisiana Supreme Court after being denied by a trial court and appeals court.[131] Unfortunately for Demesme, The Supreme Court of Louisiana declined to review the issue.[132]

Demesme's case calls into question two basic tenets of American Jurisprudence: (1) that "the accused shall enjoy . . . the Assistance of Counsel for his defense"[133] and (2) that a person is protected against self-incrimination.[134] The Fifth Amendment protections against self-incrimination[135] and Sixth Amendment guarantees of counsel[136] have

124. Tabler, *supra* note 3, at 18.
125. Niedermair, *supra* note 10, at 30.
126. *See id.*; Tabler, *supra* note 3, at 18.
127. *Id.*; *see also* Tabler, *supra* note 3 (arguing that "the case turned on whether there was a comma between *lawyer* and *dog*. If there was, Demesme had requested a *lawyer*. If not, he had spoken gibberish, asking for a *lawyer dog*—something that doesn't exist.").
128. Niedermair, *supra* note 10, at 30.
129. Tom Jackman, *The Suspect Told Police 'Give Me a Lawyer Dog.' The Court Says He Wasn't Asking for a Lawyer*, WASH. POST (Nov. 2, 2017), https://www.washingtonpost.com/news/true-crime/wp/2017/11/02/the-suspect-told-police-give-me-a-lawyer-dog-the-court-says-he-wasnt-asking-for-a-lawyer/.
130. *Id.*
131. *Id.*
132. State v. Demesme, 228 So.3d 1206, 1206 (La. 2017).
133. U.S. CONST. amend. VI.
134. U.S. CONST. amend. V.
135. Malloy v. Hogan, 378 U.S. 1, 4 (1964).
136. Gideon v. Wainwright, 372 U.S. 335 (1963).

both been incorporated under the Fourteenth Amendment and thus are binding on the states. The general rule that combines these constitutional guarantees is that an express request for an attorney immediately ends all questioning in an interrogation by a law enforcement official.[137] The Supreme Court has explicitly clarified that these protections apply to custodial interrogations through its holding in the seminal case of *Miranda v. Arizona.*[138] The ruling held that a confession violated the Fifth Amendment self-incrimination clause and Sixth Amendment right to an attorney if the suspect has not been made aware of their right.[139] The suspect must waive their rights to satisfy the *Miranda* ruling.[140] In coming to this rule, the Court reasoned that the coercive nature of custodial interrogations by police warranted these express protections towards accused persons.[141]

The more specific question of whether asking for an attorney, which is one of the four rights *Miranda* recognizes, ends an interrogation was answered in another landmark Supreme Court case, *Edwards v. Arizona*. In *Edwards,* the defendant was taken into custody for robbery and murder.[142] He was subsequently mirandized and later invoked his right to have an attorney present.[143] The next day while in jail, two officers began questioning the defendant again and this time required he answer.[144] This second session of questioning yielded incriminating statements that were admitted at trial despite objections by the defendant.[145] The Court held that once a suspect has received his Miranda warnings and invoked his right to counsel, the police may not further interrogate the suspect until the suspect has been given access to counsel, unless the suspect initiates further communication with the police.[146] Clearly, a plain application of the rules from *Miranda* and *Edwards* would mean that the police officers inter-

137. Davis v. United States, 512 U.S. 452, 461–62 (1994).

138. Miranda v. Arizona, 384 U.S. 436, 444–45 (1966) ("Prior to any questioning, the person must be warned that he. . . has a right to the presence of an attorney, either retained or appointed. The defendant may waive effectuation of these rights, provided the waiver is made voluntarily, knowingly and intelligently. If, however, he indicates in any manner and at any stage of the process that he wishes to consult with an attorney before speaking there can be no questioning.")

139. *Id.*

140. *Id.*

141. *Id.* at 448.

142. Edwards v. Arizona, 451 U.S. 477, 478 (1981).

143. *Id.*

144. *Id.* at 479.

145. *Id.*

146. *Id*. at 485–86.

rogating Demesme should have stopped when he asked for an attorney. However, Associate Justice Scott J. Crichton of the Louisiana Supreme Court had a different opinion.

Even though the Supreme Court of Louisiana could have declined Demesme's appeal without a written ruling, Justice Crichton took it upon himself to write a concurring opinion to "spotlight the very important constitutional issue regarding the invocation of counsel during a law enforcement interview."[147] In a widely mocked sentence from this concurring opinion,[148] Justice Crichton wrote, "In my view, the defendant's ambiguous and equivocal reference to a 'lawyer dog' does not constitute an invocation of counsel that warrants termination of the interview and does not violate *Edwards v. Arizona*."[149] Now, there is a very strong argument to be made that couching Demesme's speech as "ambiguous" is just unrealistic considering how popular the word "dog/dawg" is used in mainstream media and by non-African Americans. However, Justice Crichton, and other law enforcement and judicial authorities, are able to play into not understanding AAVE because of case law following *Miranda* and *Edwards* that lessen their protections.

One such case is *Davis v. United States*, which symbolized the departure of the Fifth Amendment requirement that the government bear the entire burden of protecting an individual's right against self-incrimination. The Court held, in *Davis*, that if a suspect asks for an attorney in an "ambiguous or equivocal" way in that a reasonable officer in light of the circumstances would have understood that they *might* be invoking their right to counsel, Supreme Court precedents do not require the questioning to stop.[150] In *Davis*, the ambiguity in question came about an hour and a half into the interrogation where the suspect said, "Maybe I should talk to a lawyer."[151] The Court held that this was ambiguous because of the qualifier

147. State v. Demesme, 228 So.3d 1206, 1206 (La. 2017).

148. L. Danielle Tully, *The Cultural (Re)turn: The Case for Teaching Culturally Responsive Lawyering*, 16 STAN. J. CIV. RTS. & CIV. LIBERTIES 201, 204–05 (2020) ("Angela Helm, writing for *The Root*, asserted that this decision demonstrated how 'the court system does not work for [B]lack people—especially those who lack resources.'Jordana Rosenfeld, writing in *The Nation*, argued that the decision reflected the continued refusal of the U.S. legal system to acknowledge language outside of Standard American English, which results in 'the unfair treatment of an individual based solely on the characteristics of their speech.'").

149. *Demesme*, 228 So.3d at 1207.

150. Davis v. United States, 512 U.S. 452, 459 (1994).

151. *Id.* at 455.

"maybe."[152] Although the Court tried to nuance the rule and say that suspects need not, "speak with the discrimination of an Oxford don," suspects still need to meet a "requisite level of clarity" for *Edwards* to apply and for the questioning to stop.[153] This rule gave great discretion to trial courts in assessing if a suspect invoked counsel or not and really lessened the burden on law enforcement to make sure they stopped at any hint of the word "attorney" during an interrogation.

Davis gives us one understanding of what an "ambiguous or equivocal" invocation of counsel could be. That is to say that qualifying the request for an attorney with a word like "maybe" could[154] allow police officers to argue that the request failed to be clear enough. But Demesme's statement should be distinguishable from that type of invocation. While it is possible that the court may have found Demesme's invocation of counsel "ambiguous and equivocal" because of his use of the phrase "why don't you" (which could be taken as a suggestion rather than a demand),[155] it is surprising that Justice Crichton instead referenced the phrase "lawyer dog" as the part of Demesme's statement that was confusing.[156] Justice Crichton seemed to be unsure if Demesme was asking for a literal dog rather than referring to the police officers present as "dog," that is, "man" or "friend." In this sense, Justice Crichton tries to extend the rule from *Davis* to mean that a second type of "ambiguous or equivocal" invocation is one made in a dialect that is not Standard American English. It should be clear that the practical harms of such a rule would mostly impact minorities and minority language speakers.

V. SOLUTIONS AND RECOMMENDATIONS

Obviously, trying to eradicate lingual discrimination is a massive undertaking. The road towards eliminating this pervasive type of discrimination is one that requires multiple different actors coming together with the goal of eradicating this problem. This Note suggests

152. *Id.* at 462.
153. *Id.* at 459.
154. "Maybe" is an example of "heading" or "qualifying" language. Hedging allows speakers to express opinions cautiously, as suggestions. The simple use of a qualifier does not automatically mean that the person is being unclear or ambiguous.
155. Christopher A. Hebert, *Context Is King: Lawyer Dogs, Pure Applesauce, and Your Miranda Right to Counsel*, 92 TUL. L. REV. ONLINE 1, 7 (2018) (prefacing his statement by the conjunction "if," which makes "any request for a lawyer contingent on the officer's state of mind and [thus] arguably equivocal.").
156. *Demesme*, 228 So.3d at 1207.

pointed strategies that judges and jurors specifically can take to contest linguistic prejudice. If these key actors do their part in managing linguistic discrimination, the legal system can begin, or continue, to slowly trot towards absolute equality under the law.

A. Two-Pronged Approach for Judges: Introducing Implicit Bias Auditing & Feedback System and Empowering Judicial Officers to Exercise Their Discretion

In theory, judges are primarily concerned with equal administration of justice under the law. This means that judges often try to render decisions and preside over trials with impartiality to a defendant's or witness's race, gender, religion, or other protected traits. However, if we look at statistics regarding judicial decisions, it appears that bias, largely implicit bias, exists. For instance, there have been findings that judges in Connecticut set bail at amounts that were twenty-five percent higher for Black defendants than for similarly situated white defendants.[157] Other research suggests that 80 percent of white judges more strongly associate Black faces with negative words and white faces with positive words.[158] Compare this to data from studies that sample the general population rather than the judiciary. The Charles Hamilton Houston Institute for Race and Justice at Harvard Law School concluded that 80 percent of white test-takers and 40 percent of Black test-takers tested show a pro-white bias after giving the implicit association test for measuring similar kinds of prejudices to thousands of people.[159] Moreover, 97% of judges at a conference rated themselves as better than an average judge at avoiding racial bias in their decision making process.[160] This last statistic would presume that some judges are simply unable to realize when their own implicit bias appears since they cannot all have been correct.

When comparing judges to the general population it becomes clear why this bias exists in the legal context even though the system is meant to evaluate impartially—judges are still just human beings at

157. Jeffrey J. Rachlinski, Sheri Johnson, Andrew J. Wistrich & Chris Guthrie, *Does Unconscious Racial Bias Affect Trial Judges*?, 84 NOTRE DAME L. REV. 1195, 1196 (2009).

158. Bernice B. Donald, Jeffrey Rachlinski & Andrew J. Wistrich, *Getting Explicit About Implicit Bias*, 104 JUDICATURE 75, 76 (Fall/Winter 2020-21) (using the implicit association test to reach this conclusion).

159. Terry Carter, *Implicit Bias Is a Challenge Even for* Judges, ABA J. (Aug. 5, 2016, 9:58 PM), https://www.abajournal.com/news/article/implicit_bias_is_a_challenge_even_for_judges.

160. Donald, et al., *supra* note 164, at 78.

the end of the day. Yet, they are such powerful actors in terms of maintaining impartiality and equality in courtrooms, that they necessarily share a part of the responsibility in correcting this phenomenon. Recognizing this inconsistency is the first step, but the next step requires empowering judges to use their position to help mitigate this specific form of prejudice, and to hold them accountable if they do not.

To begin with, judges need to have a realistic understanding of how pervasive these implicit biases or deep-rooted prejudices can be. They are the product of a lifetime of experiences and lessons. In fact, there is evidence that these biases can appear as early as one year old and stay with a person throughout the course of their life.[161] A small, two to three-hour accent-bias prevention training for judges cannot begin to undue the decades of experiences that informed a preconceived thought. Rather, the best strategy to help judges is to implement an auditing or feedback system. For example, a sitting judge's discretionary findings such as bail-setting, child-custody allocations, and sentencing can be audited periodically for the presence of bias. If those discretionary determinations can be audited periodically, individual judges can be told if there is statistical evidence of bias. While this solution offers a more long-term solution, if implemented immediately, it would still take some time to gather useful data from these audits to turn around to then educate judges.

Judges can also be empowered to maintain neutrality in courtrooms by using their ample discretionary power to alter courtroom practices and etiquettes without the need of a formal auditing system or policies. As demonstrated in *Doe* and *Vue*, Federal Evidence Rule 403 grants the judge the ability to exclude potentially relevant evidence if its probative value is substantially outweighed by unfair prejudice.[162] Judges in other circuits can exercise their discretionary power in similar ways if evidence of a vernacular is being used against someone.

161. Jessica Colarossi, *If Babies and Toddlers Can Detect Race, Why Do So Many Parents Avoid Talking About It?*, THE BRINK (Nov. 9, 2020), https://www.bu.edu/articles/2020/if-babies-and-toddlers-can-detect-race-why-do-so-many-parents-avoid-talking-about-it/.

162. *See* United States v. Doe, 903 F.2d 16, 20 (D.C. Cir. 1990); *see also* United States v. Vue, 13 F.3d 1206, 1213 (8th Cir. 1994).

B. Creating Juror Language Accommodation Model

The continuous participation of lay people in the legal system is a central aspect of democracy. The Sixth Amendment to the United States Constitution provides the right to an "impartial" jury in criminal prosecutions,[163] but what constitutes impartiality? The Supreme Court has answered this question through case law. In 1879, the Court prohibited disqualifying jurors based on race;[164] however, in the decades since, there still seems to be a general underrepresentation of African Americans in juries.[165] This could be a large contributing factor in cases where there are no Black people on a given jury, but the case at hand largely involves a Black person as a as a victim, suspect, or witness.

In the criminal context, juries are meant to "check" the state in that it has to prove its case to a jury before it can place someone in jail. Thus, juries act as a protection for a defendant against the state during prosecution since juries are called to review evidence and come to the ultimate decision of guilt. Because juries are meant to protect defendants, including Black and/or AAVE-speaking defendants, juries have to be held to an incredibly high standard when it comes to meting out guilty/not guilty verdicts. The Jeantel case study demonstrates what happens if we do not. In that case, two jurors admitted that they did not understand Jeantel.[166] One reason could be because of how the sound was traveling in the courthouse, but the other more likely reason is that the jurors did not understand AAVE or had so many negative stereotypes associated with AAVE, that it caused them to doubt Jeantel's credibility as a witness.

The most obvious and perhaps most efficient way to solve the issue of linguistic discrimination is to start with gathering more diverse juries. In evaluating the outcome of George Zimmerman's trial, Rickford claimed that having at least one African American person on the jury would result in people viewing Jeantel's testimony as more

163. U.S. CONST. amend. VI ("In all criminal prosecutions, the accused shall enjoy the right to a speedy and public trial, by an impartial jury of the State. . .").

164. Strauder v. State of W. Virginia, 100 U.S. 303, 310 (1879), *abrogated by* Taylor v. Louisiana, 419 U.S. 522 (1975).

165. Ronald Randall, James A. Woods & Robert G. Martin, *Racial Representativeness of Juries: An Analysis of Source List and Administrative Effects on the Jury Pool*, 29 JUS. SYS. J. 71, 82 (2008).

166. *See generally* Rickford & King, *supra* note 1 (explaining that juror B37 plus one other unnamed juror that asked for clarification were two jurors that did not understand part or all of Jeantel's testimony.)

credible because that person would have been more likely to understand AAVE and also would have been less likely to link Jeantel's speech to judgements about her intelligence and other personality traits.[167] In the jury room, they could have potentially helped translate Jeantel's speech to a variety of English more easily understood by the jury. However, compelling this thought is, it is no easy goal to attain. In *Batson v. Kentucky* itself, the seminal case that sets out to eliminate racial discrimination in jury selection by prohibiting the use of preemptory challenges to intentionally strike prospective jurors based on their race, the court debated the idea of eliminating preemptory challenges entirely and declined to.[168] Further, Black people are significantly underrepresented in jury pools from which jurors are selected as well.[169] This demonstrates the barriers at various different parts of the jury selection process that Black people must encounter before even being selected as a juror that gets to hear evidence.

After ruling this out as the best viable solution, the question then becomes how else to bridge this barrier. In the context of languages like Spanish or American Sign Language, which are viewed as legitimate, courts have accommodated jurors. Juror language accommodation is essentially assisting jurors in understanding non-native languages through translation and interpretation services to help them fully participate as jurors.[170] When discussed in academia, juror language accommodation is usually reserved to describe the situation where a nonstandard dialect, or foreign language, speaker needs assistance with SAE to be a juror—not the reverse situation that I describe, of a SAE-dominant jury misunderstanding and maligning an AAVE speaking-witness/defendant. However, if done correctly, jury language accommodation can be used to help the situation I describe as well.

There have been jury language accommodation statutory schemes that have been successful, that would need to simply be tweaked to also protect testifying AAVE speakers. For instance, in New Mexico,

167. *Id.* at 978.

168. Batson v. Kentucky, 476 U.S. 79, 107 (1986) (Mashall, T., dissenting) ("The inherent potential of peremptory challenges to distort the jury process by permitting the exclusion of jurors on racial grounds should ideally lead the Court to ban them entirely from the criminal justice system.").

169. *Illegal Racial Discrimination in Jury Selection: A Continuing Legacy*, EQUAL JUST. INITIATIVE, at 35 (June 2010).

170. Jasmine Gonzales Rose, *Color-Blind But Not Color-Deaf: Accent Discrimination in July Selection*, 44 N.Y. UNIV. R.L. & SOC. CHANGE 309, 351 (2020).

a state with a high percentage of Spanish speakers, there have been detailed procedures in place since its inception to accommodate Spanish-speaking jury members who would otherwise have a hard time understanding the complex legalese used in court.[171] In fact, accommodating non-SAE speakers is written into the New Mexico constitution.[172] If there were a Spanish speaker who had jury duty in New Mexico, they would meet with an interpreter that would provide interpretation and translation services in accordance with New Mexico courts' Non-English-Speaking Juror Guidelines.[173] Similarly, there is a federal language accommodation scheme for hard of hearing jurors. The American with Disabilities Act of 1990 and the Rehabilitation Act of 1973 require a sign language interpreter so that these jurors can participate.[174] It would take massive participation from state legislators, but it is completely possible to include interpreters during these situations for the jurors.[175]

VI. CONCLUSION

Warren Demesme's questioning should have ended after he asked for a lawyer, and Rachel Jeantel should never have been called stupid for speaking in AAVE. Linguistic discrimination against African American Vernacular speakers is still one of the few socially acceptable ways to discriminate against mostly African Americans. Yet, so many people within the legal world are unaware that this problem even exists. Judges, jurors, and police officers have all acted in discriminatory ways regarding language in both the case studies that I focused on. The way to solve this problem is to have all these actors work in tandem to begin to minimize their internal bias.

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171. *Id.* at 352.

172. N.M. CONST. art. VII, § 3 (2019) ("The right of any citizen of the state to vote, hold office or sit upon juries, shall never be restricted, abridged or impaired on account of religion, race, language or color, or inability to speak, read or write the English or Spanish languages . . .").

173. Rose, *supra* note 175, at 352.

174. 42 U.S.C. § 12132 (2012 & Supp. V 2018); 29 U.S.C. § 794(a) (2012 & Supp. V 2018); *see also Effective Communication for Persons Who Are Deaf or Hard of Hearing*, DEP'T HEALTH & HUM. SERV. (June 16, 2017), https://www.hhs.gov/civil-rights/for-individuals/disability/effective-communication/index.html (explaining that both deaf and hard of hearing individuals can be covered under the Americans with Disabilities Act and Section 504 of the Rehabilitation Act).

175. In 2010, the Drug Enforcement Agency (DEA) went through a similar thought process when it posted a job advertisement for "Ebonics translators." These AAVE experts would assist with wiretaps and would make sure that the DEA is getting reliable translations from wire taps and AAVE-speaking suspects. Sarah Netter, *Wanted: Ebonics Translator for Federal DEA Job*, ABC News (Aug. 23, 2010, 2:43 PM), https://abcnews.go.com/US/wanted-ebonics-translator-federal-dea-job/story?id=11462206.

Interpreting the People's Constitution: Pauli Murray's Intersectionality as a Method of Constitutional Interpretation

KUFERE LAING*

ABSTRACT

In *Marbury v. Madison*, the Supreme Court defined the provincial duty of federal courts: to "say" what the law is. Since this decision, jurists and scholars alike have debated what is the proper method to interpret the Constitution. The most popular, and I argue most disastrous, method is originalism—or simply, the Constitution's meaning is fixed by the Framer's imagination. Like *Dred Scott*, and other decisions demonstrate, the Framers' limited understanding of humanity results in a constitution that only protects some people, not "the People." To this end, I argue that jurists should learn from Pauli Murray's intersectionalist interpretive method. This framework begins with a straightforward premise: your rights end where another fellow's begin. By employing this interpretive lens, courts are protectors of rights and truly include "the People."

* Kufere Laing is a 2022 graduate of Howard University School of Law. I dedicate this article to my grandfather, Clarence Laing, who was a student of both Pauli Murray and Alexander Bickel. Many thanks to Professor Lisa Crooms-Robinson for her contributions during the writing process during her Fall 2021 siminar; Equality According to Pauli Murray, and also to the editors of the Howard Law Journal. Any mistakes belong to the author.

INTRODUCTION

The Constitution begins with a bold statement, "We the People, in Order to form a more perfect Union."[1] What follows is, in essence, a mission statement. In forming a "more perfect Union,"[2] the People, among other things, "establish[ed] Justice,"[3] "insure[d] domestic Tranquility," and "secure[d] the Blessings of Liberty" to themselves and

1. U.S. CONST. pmbl.
2. *Id.* Perhaps the last Union was perfect, too, but not perfect enough? That explains the Revolution, I suppose.
3. *Id.* Was justice previously unestablished?

their posterity.[4] Ultimately, the Preamble announces that the People have agreed to be governed by a new sovereign: the United States of America.

Fair enough. Except that not all people that were subject to the United States' jurisdiction were parties to the agreement. In fact, Native Americans, Black people, White women, and to a lesser-degree, non-property-owning White men, were explicitly excluded from the Constitution's construction.[5] Simply put, the Framers made it clear, "We the People" did not extend to all the people that were subject to America's authority.[6]

Actually, the Constitution went a step further: it acknowledges that there were different types of people—a type that may be subjugated.[7] In devising the formula for the apportionment of taxes and representation, States were to count the "whole Number of free Persons," exclude untaxed "Indians," and "three fifths of all other Persons."[8] The Constitution also forbade Congress from imposing *any* regulation on the "importation" of "such persons" until 1808, yet permitted a "Tax or duty . . . be imposed on such Importation."[9] And if that were not enough, it mandated that people who escaped enslavement be returned to their original owner.[10] A Black person's freedom, therefore, required the permission of an enslaver.

Still, Black people unequivocally rejected the legal fiction that they were not fully people.[11] Whether through armed struggle or legal advocacy, Black people offered America many opportunities to redeem itself and recognize their dignity. Ultimately, through civil war,

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4. Id.

5. Charles A. Beard, AN ECONOMIC INTERPRETATION OF THE CONSTITUTION OF THE UNITED STATES 16 (Dover, ed. 2004).

6. Lisa A. Crooms-Robinson, *Is the Third Time the Charm? Reconstructing Personhood and Reimagining "We the People*," 43 HUM. RTS. 28 (2017-18).

7. *Id.*

8. U.S. CONST. art. I, § 2.; *see also*, *id.*

9. U.S. CONST. art. I, § 9; *see also*, Crooms-Robinson, *supra* note 6.

10. U.S. CONST. art. IV, § 2.; *see also*, Crooms-Robinson, *supra* note 6.

11. *See* CEDRIC ROBINSON, BLACK MARXISM: THE MAKING OF THE BLACK RADICAL TRADITION 125 (2000). Robinson, in explaining racial-capitalism as an intersecting system of oppression, explores Black resistance. At the core of enslavement and the reduction of Black people to capital is the fallacy that Black people accepted that their inferiority, if in fact, they were not inherently inferior. That, of course, is not true. "We now 'know' what the master class certainly knew but for so long publicly denied only to be confronted with the truth in its nightmares, its sexual fantasies, and rotting social consciousness: the enslaved were human beings. But the more authentic question was not whether the slaves (and the ex-slaves and their descendants) were human. It was, rather, just what *sort* of people they were . . . and could be. Slavery altered the conditions of their being, but it could not negate their being."

the fascist regime that denied Black humanity was torn apart and forced to reconstruct.[12] Since, constitutional challenges to laws that subjugate based upon a person's identity boil down to a straightforward question: Who are "the People?"

Though the Declaration of Independence asserts that governments "deriv[e] their just powers from the consent of the governed,"[13] even after the Civil War, Black people have yet to explicitly consent to America's governance.[14] Left without an alternative, Black people have sought to cure the Constitution's birth defects by providing a humane definition of "the People."

No one exemplifies this goal more than Pauli Murray, perhaps the most ambitious and effective advocate of a humane Constitution. Whether as an educator-organizer or as a lawyer, Murray developed and advanced a straightforward argument: Every person has dignity that the Constitution must recognize and protect. This is most demonstrable through Murray's construction of the Fourteenth Amendment's Equal Protection Clause.

But to reduce Murray's jurisprudence to the Equal Protection Clause would be a mistake. Murray also provided an intersectional framework to reinterpret "We the People" and freed the Constitution from the limits of the Framers' imagination. Murray, therefore, articulates intersectionality as a liberatory and equitable theory of constitutional interpretation.

In three parts, this Article attempts to explain Murray's intersectionalist framework as more than a specific interpretation of the Equal Protection Clause, but as a general method of constitutional interpretation. To start, Part I examines the complexities of interpretive methods and judicial review through two cases: *Marbury v. Madison* and *Dred Scott v. Sandford*. In tandem, *Marbury* and *Dred*

12. *See* W.E.B. Du Bois, Black Reconstruction in America 1860–1880 184. "The true significant of slavery in the United States to the whole social development of America, lay in the ultimate relation of slaves to democracy. What were to be the limits of democratic control in the United States? If all labor, black as well as white, became free, were given schools and the right to vote, what control could or should be set to the power and action of these laborers? Was the rule of the mass of Americans to be unlimited, and the right to rule extended to all men, regardless of race and color, or if not, what power of dictatorship would rule, and how would property and privilege be protected? This was the great and primary question which was in the minds of the men who wrote the Constitution of the United States and continued in the minds of thinkers down through the slavery controversy. It still remains with the world as the problem of democracy expands and touches all races and nations."

13. The Declaration of Independence

14. *See, e.g.*, Samuel Macrosson, *Colorizing the Constitution of Originalism: Clarence Thomas at the Rubicon*, 16 Law & Ineq. 429, 470 n. 170 (1998).

Scott, showcase the issue that Murray attempted to solve: How are judges to interpret the Constitution and who does the Constitution protect? Part II explains that answering this question is largely a question of identity politics, and originalism, where applied, is an extension of white and male supremacist identity politics. This identity politic keeps *Dred Scott* alive, and if the Constitution will fully repudiate this decision, a new interpretive method is required. Part III thus provides the alternative: Intersectionality. Here, I argue that Pauli Murray's interpretation of the Equal Protection Clause is an example of intersectional jurisprudence that should be expanded to resolve issues of constitutional and interpretive issues broadly. In conclusion, I contextualize Murray's jurisprudence within a larger social movement that marries constitutional interpretation and social justice.

I. JUDICIAL REVIEW: FROM MARBURY TO DRED SCOTT

Constitutional law is largely built around answering two questions: (1) does the Constitution recognize the right at issue and (2) if it does, who holds the right? As complex as those questions are, both are subsequent to a threshold question: why do federal courts, and not another branch of government, determine what rights exist and who holds those rights? The answer is hotly contested and requires an analysis of what judicial review is, how it came to be, and its function in defining constitutional rights.

A. Doctrinal Roots: *Marbury v. Madison*

In defining the role and duty of the federal courts through judicial review, *Marbury v. Madison* "is the single most important decision in American constitutional law."[15] Specifically, Chief Justice Marshall's opinion holds that, "[i]t is emphatically the province and duty of the judicial department to say what the law is."[16] The "very essence of judicial duty," *Marbury* continues, is to decide whether a law passed by the legislature comports with the Constitution.[17] And where, as in *Marbury*, a law is "repugnant" to the Constitution, under the Supremacy Clause, the judiciary must declare that the law is void.[18]

15. Erwin Chemrinsky, Federal Jurisdiction 12 (7th ed.).
16. Marbury v. Madison, 5 U.S. 137, 177 (1803).
17. *Id.*
18. *Id.* at 180.

Marbury's reliance on the Supremacy Clause requires particular attention. As always, to understand the clause, we must begin with the text:

> This Constitution, and the laws of the United States which shall be made in pursuance thereof; and all treaties made, or which shall be made, under the authority of the United States, shall be the supreme law of the land; and the judges in every state shall be bound thereby, anything in the Constitution or laws of any State to the contrary notwithstanding.[19]

Something must be missing, right? What language in the Supremacy Clause permits a federal court to declare a law void? Moreover, how is a federal judge to determine what laws are, in fact, repugnant to the Constitution?

In Alexander Bickel's canonical work, *The Least Dangerous Branch*, he argues that some of *Marbury*'s reasoning rests on infirm ground.[20] *Marbury*, Bickel asserts, "does not derive from any explicit constitutional command," and its reliance on the Supremacy Clause "upends the plain purpose of the clause."[21] To Bickel, the Supremacy Clause's natural meaning is that federal law reigns supreme to state law.[22] Nothing more, nothing less.

Bickel further challenges *Marbury*'s holding that the Supremacy Clause requires federal judges to exercise judicial review. State judges (who unlike federal judges are in the Clause's text), the argument goes, can "just as well uphold the Constitution."[23] And where—as there was in *Marbury*—a conflict between a federal statute and the Constitution, the resolution "can be said to have been answered by Congress and the President in favor of the validity of the statute which they enacted."[24] Last, and perhaps most importantly, "a statute's repugnancy to the Constitution is in most instances not self-evident; it is, rather, an issue of policy that someone must decide."[25] Why is the decisionmaker a judge, and not the legislature, or the President, or "ultimately and finally the people through the electoral process?"[26]

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19. U.S. CONST. art. VI.

20. ALEXANDER M. BICKEL, THE LEAST DANGEROUS BRANCH: THE SUPREME COURT AT THE BAR OF POLITICS (1986).

21. *Id.*

22. *Id.*

23. *Id.* at 10.

24. *Id.*

25. *Id.* at 3.

26. *Id.*

Though Bickel recognizes that *Marbury*'s holding is "obviously sensible," "implied" by the Constitution's scheme, and "a present instrument of government," he also recognizes that judicial review presents a grave danger: counter-majoritarian rule.[27] The ability to invalidate a statute, Bickel asserts, has the "tendency . . . to [seriously] weaken the democratic process."[28] Put differently, when the courts invalidate a statute, they usurp legislative power and "dwarf[ ] the political capacity of the people."[29] In turn, the people become politically illiterate and forget that elections matter.

True enough. But to some, Bickel overstates the threat of counter-majoritarian judging. Consider John Hart Ely's response. Ely agrees, "a body that is not elected or otherwise politically responsible in any significant way is telling the people's elected representatives that they cannot govern as they'd like," is judicial review's central function and problem.[30] Majority rule, Ely finds, "is the core of the American governmental system."[31] Yet, at the same time, "a majority with untrammeled power to set governmental policy is in a position to deal itself benefits at the expense of the remaining minority . . . [t]his too has been understood from the beginning."[32] The judiciary's "task has been and remains that of devising a way or ways of protecting minorities from majority tyranny that is not a flagrant contradiction of the principle of majority rule."[33]

Still, both perspectives converge on a critical question: What is the proper restraint on judicial power. *Marbury* requires that the judiciary determine what the law is. It also requires that judges apply the Constitution and void laws that offend its meaning. But *Marbury* does not answer the logical question that follows: How should the judiciary (judges) interpret the Constitution.

27. *Id.* at 13, 16.
28. *Id.* at 21.
29. *Id.* at 31.
30. JOHN HART ELY, DEMOCRACY AND DISTRUST: A THEORY OF JUDICIAL REVIEW 5 (1980).
31. *Id.* at 7.
32. *Id.*
33. *Id.* at 8.

B. Dred Scott v. Sandford's Legacy: Originalism and Judicial Review

Following *Marbury*, the Court waited another fifty years before exercising judicial review to strike down a law as unconstitutional.[34] The case? *Dred Scott v. Sandford*, undoubtedly the most embarrassing opinion in the Supreme Court's history. Despite its infamy, there are two reasons why *Dred Scott* remains an important starting point to explore both judicial review and constitutional interpretation. First, *Dred Scott* uses originalism as a method of constitutional interpretation: its application demonstrates that originalism was flawed then and remains flawed today. Second, *Dred Scott* also demonstrates judicial review as counter-majoritarian rule and the dangers of judicial overreach.

1. Dred Scott v. Sandford's Historical Background

Dred Scott[35] is a case about a Black family attempting to use the federal courts to escape enslavement.[36] Between 1837 and 1840, the Scotts were moved between "free territory" and "slave territory" three times.[37] These forced movements laid the groundwork for the family's legal attack on slavery in Missouri state court.[38] Ultimately, the Missouri Supreme Court ruled against them.[39]

But not to be deterred, the Scotts sued again in federal court. There, they advanced two claims: (1) that they were no longer enslaved because they spent time living in "free territory" as designated in the Missouri Compromise and (2) that Sanford assaulted them after he whipped each family member for suing him in state court.[40] Thus, there were two jurisdictional hooks for their federal suit: (1) diversity jurisdiction—Sanford, was a citizen of New York, while the Scotts were citizens of Missouri,[41] and (2) federal question jurisdiction, because the Court needed to determine whether the Scotts were legally

34. BICKEL *supra* note 20, at 14.
35. Dred Scott v. Sandford, 60 U.S. 393 (1857).
36. Lea VanderVelde & Sandhya Subramanian, *Mrs. Dred Scott*, 106 YALE L.J. 1033, 1034 (1997). In fact, the entire family is a party to the suit. *Id.* at 1042.
37. *Id.* at 1043.
38. *Id.* at 1059. Of note, this determination was incorrect. In *Mrs. Dred Scott*, VanderVelde and Subramania demonstrate the significant life differences and argue that Harriett Scott had a stronger claim to freedom under state law.
39. *Id.* at note 111.
40. Jack M. Balkin & Sandford Levinson, *Thirteen Ways of Looking at Dred Scott*, 82 CHI.-KENT L. REV. 49, 52 (2007); *see also Scott*, 60 U.S. at 554–555.
41. *Scott*, 60 U.S. at 403.

free because they lived in areas where enslavement was forbidden under the Missouri Compromise.[42] I address the Court's analysis on each issue independently, then in tandem.

2. The Citizenship Question

Chief Justice Taney begins his analysis of the case by framing the issue:

> Can a Negro, whose ancestors were imported into this country, and sold as slaves become a member of the political community formed and brought into existence by the Constitution of the United States, and as such become entitled to all the rights and privileges, and immunities, [guaranteed] by that instrument to the citizen? One of which is the privilege of suing in a court of the United States in the cases specified in the Constitution.[43]

His answer is now well-known: No, federal courts do not have jurisdiction to adjudicate cases brought by Black people because they are not American citizens. The opinion reasons that Black people were, "beings of an inferior order, and altogether unfit to associate with the [W]hite race, either in social or political relations."[44] They "had no rights which the [W]hite man was bound to respect; and . . . might justly and lawfully be reduced to slavery for his benefit."[45] "Naturally," the Court concluded that Black people "are not included, and were not intended to be included, under the word 'citizens' in the Constitution, and can therefore claim none of the rights and privileges which that instrument provides and secures to the citizens of the United States."[46]

Its vulgarity notwithstanding, *Dred Scott* had no shortage of authoritative support; principally, the Constitution itself thanks to its revered authors. At the time of the Constitution's ratification, the Court pontificates, it was "fixed and universal in the civilized portion of the [W]hite race" that Black people were "an ordinary article of merchandise and traffic, whenever a profit could be made by it."[47] In support, the majority surveys legal enslavement throughout the colonies.[48] Next, it grounds its reasoning in the Declaration of Indepen-

42. *Id.* at 431–32.
43. *Scott*, 60 U.S. at 397.
44. *Id.* at 407–08.
45. *Id.*
46. *Id.* at 404.
47. *Id.* at 407.
48. *Id.* at 408–410.

dence, concluding that "the enslaved African race were not intended to be included" within the proclamation that "all men are created equal" and "are endowed by their Creator with certain unalienable rights."[49] Because to include Black people "would be utterly and flagrantly inconsistent" with the "distinguished men who framed the Declaration of Independence."[50] To assert that Black people were equal and endowed with rights from the Creator would result in "deserved . . . universal rebuke and reprobation."[51]

"This state of public opinion had undergone no change when the Constitution was adopted, as is equally evident from its provisions and language."[52] Though *Dred Scott* concedes that the preamble "does not define what description of persons are intended to be included" in its terms, or "who shall be regarded as a citizen and one of the people," it concludes that such a definition would be superfluous.[53] Indeed, it was so clear that Black people were not fully people that "no further description or definition was necessary."[54] And if further proof were needed, and seemingly it was not, then *Dred Scott* examines the Constitution and remarks that,

> The only two provisions which point to them and include them, treat them as property, and make it the duty of the Government to protect it; no other power, in relation to this race is to be found in the Constitution; and as it is a Government of special, delegated, powers, no authority beyond these two provisions can be constitutionally exercised.[55]

Hence, the Court determined that it could not unfix the Constitution's "truth" that Black people were not entitled to its protections as people rather than property. "It was not the province of the Court to decide upon the justice or injustice, the polity or impolicy" of the words "people of the United States."[56] Rather, that decision "belonged to the political or law-making power, to those who formed the sovereignty and framed the Constitution."[57] In short, *Dred Scott*

49. *Id.* at 410.
50. *Id.*
51. *Id.*
52. *Id.* at 411.
53. *Id.*
54. *Id.*
55. *Id.* at 426.
56. *Id.* at 405.
57. *Id.*

holds that Black people cannot be citizens because the Framers did not consider Black people citizens.[58]

But *Dred Scott*'s citizenship discussion was overbroad, simplistic, and inaccurate.[59] As Justice Curtis's dissent reasons, when the Articles of Confederation were ratified, some Black people, though descendants of enslaved Africans were citizens of New Hampshire, Massachusetts, New York, New Jersey, and North Carolina.[60] Incorporating language from the North Carolina Supreme Court's *State v. Manuel* decision, Justice Curtis distinguishes enslaved people as property from formerly-enslaved people as citizens.[61] The moment "the disqualification of slavery was removed, they became persons."[62]

Though the Reconstruction Amendments overturned *Dred Scott*, its citizenship discussion remains relevant and had a lasting effect on constitutional law. Pre-*Dred Scott*, Bickel argues that citizenship was largely irrelevant, and its importance post-*Dred Scott* has centered on exorcising *Dred Scott* from constitutional doctrine.[63] By enshrining rights within citizenship, what it means to be a citizen or a member of "the People" underlies all questions of fundamental rights.

3. The Missouri Compromise and Judicial Review

Though the *Dred Scott* majority acknowledged that there was no jurisdiction to hear the Scott family's claim, it proceeded to analyze the federal question: whether the Missouri Compromise was constitutional. Consider the brazenness of that decision. As a procedural matter, the Court held that the Scotts were not citizens and had no right to bring a claim in federal court. In this sense, the Scotts did not have standing and there was no Article III "Case and Controversy," without a case and controversy, the Court did not have the power to reach the merits: whether the Scotts were emancipated by living in territory governed under the Missouri Compromise.[64]

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58. *See, e.g.*, HOWARD ZINN, A PEOPLE'S HISTORY OF THE UNITED STATES 33 (1980) (documenting that James Madison once bragged that he "could make $257 on every Negro in a year, and only spend $12 or $13 on his keep).; *see also* JERRY FRESIA, TOWARD AN AMERICAN REVOLUTION: EXPOSING THE CONSTITUTION & OTHER ILLUSIONS 13–22 (1988).

59. Alexander Bickel, *Citizenship in the American Constitution*, 15 ARIZ. L. REV. 369, 370 (1973).

60. *Dred Scott*, 60 U.S. at 572.

61. *Id.*

62. *Id.*

63. Bickel *supra* note 59, at 372.

64. *See also* Sean Kammer, *"Whether or Not Special Expertise is Needed": Anti-Intellectualism, the Supreme Court, and the Legitimacy of Law*, 63 S.D. L. REV. 287, 321 (2018).

What's more, the majority acknowledged that its analysis of the Missouri Compromise "makes very little, if any difference in a pecuniary or personal point of view to either party."[65] Yet, it justified its procedural overreach by surmising that the lower court's analysis of the Missouri Compromise "might be drawn into precedent, and lead to serious mischief and injustice in some future suit."[66] This, of course, suggests that the Court was blind to its own serious mischief and injustice in the case at hand. This passage, perhaps better than any in the Court's history, demonstrates the dangers of judicial review and Bickel's qualms with *Marbury*.[67]

Unsurprisingly, the subsequent legal analysis is just as flawed. To begin, the majority's reasoning derives from the premise that Black people are property and "have no Fifth Amendment rights to liberty competitive with their masters' Fifth Amendment rights to own them."[68] Thus, under the Fifth Amendment, the majority found that the Missouri Compromise deprived enslavers of a substantive due process right to own Black people, but what *process* lacked in Congress' ban of enslavement in the territories?[69]

Yet, *Dred Scott*'s biggest issue exemplifies Bickel's concerns about judicial restraint: The majority found a constitutional ambiguity based upon a policy judgment. Indeed, *Dred Scott* "rendered unconstitutional the political positions of both the nascent Republican Party and of Stephen Douglas and other northern Democrats on the question of slavery in the territories."[70] Thus, the Court prevented Congress from mediating the Nation's most pressing national issue. The result? Civil War.[71]

4. Scott's Modern Relevance: Originalism and Judicial Restraint

Though the Civil War and the Reconstruction Amendments abolished *Scott*'s precedential value, *Dred Scott*'s doctrinal relevance remains. That is because *Dred Scott*'s originalist method of constitutional interpretation remains the preferred popular tool for

65. *Id.*
66. *Id.*
67. *See also* Bush v. Gore, 531 U.S. 98 (2000).
68. Jamal Greene, *The Anticanon*, 125 HARV. L. REV. 379, 407 (2011).
69. *Id.*
70. *Id.*
71. This is not to suggest that *Scott* is the lone cause of the Civil War or that Civil War was avoidable had the majority stopped its analysis upon holding that Black people could not be citizens. As Greene explains, "*Dred Scott* told us that we had to take or leave a Constitution that enshrined white supremacy. We left it, and we are better for it." *Id.* at 412.

some judges and scholars. Despite the many societal changes since *Dred Scott*—principally, the Civil War—originalism's attachment to the Framers' flaws inheres and so too does an attachment to their limited definitions of citizenship, personhood. In turn, this restricts who is entitled to the Constitution's protections.

C. Originalism and Race Post-Dred Scott

Over 200 years later after *Dred Scott*, the late Justice Scalia echoed its method of constitutional interpretation. In his view, the Constitution was to be understood without any evolution "brought about through social change [or] judicial innovation."[72] "The purpose of constitutional guarantees," Justice Scalia clarified, "is precisely to prevent the law from reflecting certain changes in original values that the society adopting the Constitution thinks fundamentally undesirable."[73] Perhaps parroting Bickel, "[a] democratic society does not, by and large, need constitutional guarantees to insure that its laws will reflect 'current values.' Elections take care of that quite well."[74]

The similarities in Justice Scalia's argument supporting originalism and Chief Justice Taney's belief that, "[i]t [was] not the province of the court to decide upon the justice or injustice, the policy or impolicy" of the words "people of the United States" are easily apparent.[75] Both seemingly agree that jurists are only to "interpret the instrument" the Framers formed "according to its true intent and meaning when it was adopted."[76]

That perspective is particularly troublesome when examining *Dred Scott*'s logic regarding Black citizenship. Citing the Declaration of Independence, the *Dred Scott* majority asserts that White people have "self-evident" and "unalienable" rights that derive from the "Creator."[77] Though the newly-created sovereign could restrict and define certain rights, the Framers never sacrificed White people's unalienable human rights. That is because the Framers believed that their human rights derived from God, not the government. And note, their belief that government derives from *them*. To "order" things: (1) God endows White men with divine rights, (2) White men create a

72. Jamal Greene, *On the Origins of Originalism*, 88 TEX. L. REV. 1, 9 (2009).
73. Antonin Scalia, *Originalism: The Lesser Evil*, 57 U. CINN. L. REV. 849, 864 (1989).
74. *Id.*
75. *Scott*, 60 U.S. at 405.
76. *Id.*
77. *Id.* at 410.

sovereign government, giving it with the ability to limit the restrict the exercise of some of their otherwise unfettered freedom; but (3) the government's ability to restrict White men's freedom must bow to the "unalienable rights" to life, liberty, and property that derive from the Creator.

This "ordering" did not apply to Black people: *Dred Scott* submits that Black people had no rights that White men were bound to respect. In other words, because God did not bestow any divine rights to Black people, they were only entitled to those that White men, who controlled the government, saw fit to recognize. Black people, after all, were of a mixed character: chattel and human—not God and human.

Thus, although the Fourteenth Amendment overturned *Dred Scott*'s holding, it could not uproot its logical underpinnings. And as constitutional law scholar Jamal Greene explains, originalism's commitment to *Dred Scott*'s logic reinforces a long-documented commitment to denying Black humanity and membership in the political community.[78] That is because originalism remains attached to historical moments that have never affirmed Black humanity.[79]

Take Justice Scalia's questioning at oral argument on cases involving affirmative action and voting rights as examples. During the *Fisher v. University of Texas*[80] oral argument, he suggested that the University of Texas's consideration of race in admissions may not be a compelling government interest. In fact, Justice Scalia seemed particularly sympathetic to "those who contend that it does not benefit African Americans to get the University of Texas where they do not do well, as opposed to having them go to a less-advanced school—a slower-track school where they do well."[81] As one critic explained, this haphazard endorsement of the "mismatch theory" suggested a belief that Black students "did not belong at elite institutions."[82] Not to mention the troubling implications in Justice Scalia's odd, albeit not fully-defined, ideas of "slower-tracked," "advanced," and what it means to "do well."

78. Jamal Greene, *Originalism's Race Problem*, 88 DENV. U.L. REV. 517, 521 (2011).

79. *Id.*

80. Fisher v. Univ. of Tex., 570 U.S. 297 (2013).

81. Transcript of Oral Argument at 67, Fisher v. Texas, 570 U.S. 297 (2013) (No. 11-345).

82. *See, e.g.*, Anemona Hartocollis, *With Remarks in Affirmative Action Case, Scalia Steps Into 'Mismatch' Debate*, N.Y. TIMES (Dec. 10, 2015), https://www.nytimes.com/2015/12/11/us/with-remarks-in-affirmative-action-case-scalia-steps-into-mismatch-debate.html.

Justice Scalia had a similarly disturbing quote at oral argument in *Shelby County v. Holder*.[83] There, he suggested that the Voting Rights Act passed through Congress with almost unanimous support because of "a perpetuation of racial entitlement."[84] "Whenever a society adopts racial entitlements," Justice Scalia pontificated, "it is very difficult to get out of them through the normal political processes."[85] Justice Scalia, then provided his policy concerns, "I am fairly confident [the Voting Rights Act] will be reenacted in perpetuity unless [ ] a court can say it does not comport with the Constitution."[86] Senators, Justice Scalia suggests, are simply afraid of voting against the Voting Rights Act: "Even the name of it is wonderful," he admits, "Who is going to vote against that in the future?"[87] This monologue only foreshadowed Justice Scalia's vote declaring Congress's formula unconstitutional.[88] It also epitomizes counter-majoritarian, policy-based constitutional interpretation.

Even if Justice Scalia's oral-argument diatribes and his votes in *Fisher* and *Shelby County* do not reflect the best of originalism, Greene's argument remains. Because originalism is fixated on preserving a white supremacist past, it cannot disavow *Dred Scott*'s rejection of Black humanity.

So why use it? Originalism is not simply a constitutional theory. It is a homage to the Framers. It embraces their ideals. It sanitizes America's white-supremacist foundation. Originalism as a method of constitutional interpretation, therefore, is an affirmation of what America was, as what America is—and what America should or can be. More importantly, it decides *who* determines what America is—and what America should or can be. Originalism is, quintessentially, identity politics.

II. INTERPRETIVE FRAMEWORKS AND IDENTITY POLITICS

Ultimately, *Marbury* and *Dred Scott* explain that judicial review is enshrined in our constitutional scheme. But judicial review's enshrinement is a by-product of judicial action. The irony here is too

83. 570 U.S. 529 (2013).
84. Transcript of Oral Argument at 47, Shelby Co. v. Holder, 570 U.S. 529 (2013) (12-96).
85. *Id.*
86. *Id.*
87. *Id.* at 48.
88. *Shelby County*, 570 U.S. at 557.

obvious to ignore: judicial review's relevance is attributable to judges, through judicial review, carving out constitutional power. Today, we must live with judicial review, and it has since proven to be useful. That does not, however, sufficiently justify judicial review on its own terms, nor does it mean that judicial review is inherent in our constitutional scheme. This section examines judicial review on its own terms and examines whether it has another justification other than utility. I conclude that judicial review is an important mediator in political disputes, thus a judge's use of an interpretive method determines how "winners" and "losers" are chosen.

Let's continue to engage Alexander Bickel's argument as he introduces an important idea: constitutional law cases require federal courts to weigh the values of the American people. Bickel begins with a broad observation: government must both serve "immediate needs" and retain "enduring values."[89] The question thus becomes which government institution—"if any single one in particular—should be the pronouncer and guardian of values?"[90] The elected branches, Bickel asserts, "are ill fitted, or not so well fitted as the courts," to guard values.[91] That is because elections "are surely incapable of sustaining a working system of general values specifically applied."[92] Rather, democracies function because there is the consent of the governed. Elected officials, therefore, are placed in their positions to resolve issues without consulting their constituents on the immediate problem. Approval or disapproval of action, i.e., whether the elected officials' decisions comport with the people's value system, is shown through the power to "displace the decision makers and to reject any part of their policy."[93] Thus, the people safeguard their values through elections, and legislators must be given the freedom to legislate—judicial review, need not disrupt that process.

When distilled, Bickel presents a formidable argument. In a democracy, values are defined through the electoral process. The people simply vote their values; hence, values are political. Federal judges are unelected; therefore, they do not directly represent the people's values. What's more because judges are unelected and the Supreme Court's constitutional interpretations are unreviewable by another

89. BICKEL, *supra* note 20, at 24.
90. *Id.*
91. *Id.* at 27.
92. *Id.*
93. *Id.*

branch, the Court should be especially careful to declare that a value is unconstitutional. Unfettered power to void a popular belief is antithetical to democracy. Accordingly, the judge's job is simple: Stay out of the legislative process and respect the people's policy preferences.

But Bickel's theory relies on a few fallacies. To begin, it ignores America's long history of restricting who can vote in elections based upon identity.[94] It also ignores that following the Civil War, the federal judicial power was expanded to mitigate the threat of white-supremacist majoritarian tyranny.[95] Under Bickel's framework, however, it is only possible for judges to safeguard the values voters, with little inquiry into the political process and the voters' identity. Equity is assumed.

Second, presidents (who appoint federal judges) and senators (who confirm them) may be elected because the people want them to appoint and confirm judges who share their values. That is why presidents often include judicial appointments in their platforms while campaigning and appointment judges that align with their political preferences once in office.[96] Hence, judges like legislation can represent the people's values.[97]

Finally, and perhaps most importantly, the risk of countermajoritarian rule is not unique to the judiciary. The Senate, due to its apportionment,[98] and the filibuster,[99] are both examples of countermajoritarian rule.[100] As is the electoral college, which governs presidential elections. Federal elections—Bickel's remedy for bad govern-

94. *See, e.g.*, Javonte Anderson, *Challenges to Black Voting Rights Hark Back to Jim Crow Era*, USA TODAY, https://www.usatoday.com/story/news/2021/03/05/black-voting-rights-reconstruction-jim-crow/6919352002/ (last updated Mar. 5, 2021, 8:37 PM).

95. *See* Edward A. Purcell, Jr., *The Particularly Dubious Case of* Hans v. Louisiana: *An Essay on Race, History, and "Federal Courts*," 81 N.C. L. REV. 1927 (2003).

96. Jamelle Bouie, *Let's Bring the Supreme Court Back Down to Earth*, N.Y. TIMES (Feb. 1, 2022), https://www.nytimes.com/2022/02/01/opinion/biden-breyer-supreme-court.html; *See also* A. Frank Reel, *When a Switch in Time Saved Nine*, N.Y. TIMES (Nov. 10, 1985), https://www.nytimes.com/1985/11/10/opinion/l-when-a-switch-in-time-saved-nine-143165.html.; Damon Root *A Switch in Time Saves Nine*, REASON (Jan. 1, 2009, 3:00 PM), https://reason.com/2009/01/22/a-switch-in-time-saves-nine/.

97. *See, e.g.*, Dan Mangan, *Trump: I'll appoint Supreme Court justices to overturn* Roe v. Wade *abortion case*, CNBC (Oct. 19, 2016, 9:31 PM), https://www.cnbc.com/2016/10/19/trump-ill-appoint-supreme-court-justices-to-overturn-roe-v-wade-abortion-case.html.

98. *See generally* John D. Griffin, *Senate Apportionment as a Source of Political Inequality*, 31 LEGIS. STUD. Q. 405 (2006).

99. Brian Bennett, *Joe Biden Defended the Filibuster for Years. Now He Wants to End it for Voting Rights*, TIME (Jan. 11, 2022, 11:44 PM), https://time.com/6138696/joe-biden-voting-rights-filibuster/.

100. *See generally* Pamela Karlan, *The New Countermajoritarian Difficulty*, 109 CAL. L. REV. 2323 (2021).

ance—are themselves, counter majoritarian. In this way, Bickel's focus on counter-majoritarian judging, and not a counter-majoritarian Constitution, confuses the forest for the trees.

So perhaps, the role of the judiciary is to mediate value-disputes, not safeguard values that may not reflect the people's will.[101] In carrying out this role, federal courts should emphasize fair processes: whether by taking a preeminent role in ensuring fair elections or in legislative or constitutional disputes placing particular emphasis on the political process from whence the challenged policy derives, rather than the policy itself.[102]

This is not to say that the courts will not declare a winner in providing a standard for value-disputes. Nor is it to say that the "proper process" is not an inherent value judgment, too. Indeed, Bickel is correct to caution that a judge may unnecessarily impute their values, and in doing so, fail to act as a fair mediator. Judges will ultimately have to choose a side, no one contests that responsibility. It is also accepted that judges must choose a side fairly. Determinations of fairness, therefore, require examination of interpretive frameworks—the judge's general approach to reading law.

This interrogation of interpretive frameworks must occur outside of the legal silo. That is because values, and the law, do not operate in a vacuum. Both encompass many disciplines. Hence, analyses of interpretive methods are best analyzed with assistance from other fields of knowledge.[103] Since judging and interpretation are political, let's examine interpretive methods as a manifestation of political ideology.

A. Identity Politics and Interpretive Methods

Though the word "politics" has many meanings and connotations, here I employ the general definition: Politics is "the fight over whose views and values should prevail in the allocation of scare societal resources, and the struggle over who receives various social benefits and

101. For example, to some, *Shelby County* represented a value of counter-majoritarian rule. *See* David A. Love, *The courts have served as an anti-democratic force for much of U.S. History*, WASH. POST (Nov. 3, 2021, 9:00 AM), https://www.washingtonpost.com/outlook/2021/11/03/courts-have-served-an-anti-democratic-force-much-us-history/. Should the Court have protected that value?

102. *See, e.g.*, United States v. Carolene Products Co., 304 U.S. 144, 152 n.4 (1938); Todd B. Adams, *Opportunity Hoarding, the Equal Protection Clause, and Judicial Review in* Schuette v. Coalition to Defend Affirmative Action, Integration, and Immigrant Rights and Fight for Equality By Any Means Necessary (BAMN), 98 U. DET. MERCY L. REV. 167 (2021).

103. *See, e.g.*, Ronald Dworkin, *Law as Interpretation*, 60 TEX. L. REV. 527 (1982).

who bears the costs."[104] As Bickel explains in his *Marbury* discussion, much of judicial review is discretionary. In this context, political ideology examines "the package of ideas and preferences" that move the judge to action.[105] It recognizes that "the legal and the political" are intertwined and looks at the fundamental question of "how judges come to embrace certain legal or constitutional ideologies in the first place."[106]

The first, and most fundamental, embrace is with the judge's identity. That is because political activity "is animated by efforts to define and defend who I am, or we are, or you are, or hope to, or hope to be seen to be."[107] Judging and political activity require "making comparisons and choices among—and commitments to—values and interests and groups and individuals."[108] In short, there are winners and losers.

At best, judges use ideology to provide a principled evaluation of who should win or lose. That is ultimately guided by the judge's interpretation of, to quote *Marbury*, "what the law is." But because the law is written by people attempting to define and defend the nation, the judge's interpretation is a testament to whether the judge agrees with the law's authors.

1. Originalism as Identity Politics

Originalism, like many theories, is not a monolith. Therefore, before explaining originalism as an identity politic, it is necessary to declare whose originalism, and by extension, whose identity politic, I am defining. This is especially important because identity politics are inherently subjective, though originalists argue that their interpretive framework is objective.[109]

This inquiry examines the originalist approach that "does not allow constitutional interpretations to prohibit what was permitted at the time of the relevant clause's enactment."[110] Take *Brown* for example. When the Fourteenth Amendment was enacted, school deseg-

104. Bradley W. Joondeph, *The Many Meanings of Politics in Judicial Decision Making*, 77 UMKC L. REV. 347, 348 (2008).
105. *Id.* at 358.
106. *Id.*
107. Richard D. Parker, *Five Theses on Identity Politics*, 29 HARV. J.L. & PUB. POL'Y 53, 53 (2005).
108. *Id.*
109. Jamal Greene, *Selling Originalism*, 97 GEO. L.J. 657, 662 (2009).
110. Id. at 663; *also see*, Antonin Scalia, *Response*, *in* A MATTER OF INTERPRETATION: FEDERAL COURTS AND THE LAW, 129, 147–49 (Amy Gutmann ed., 1997).

regation was permitted, under this originalist approach, *Brown* was wrongly decided.

Originalist justifications suggest that its approach provides a solution to Bickel's warning of counter-majoritarian judging. The central thesis is that originalism "enforces the Constitution's status as law" because it is "impersonal" and "transparent."[111] But other approaches due to their fluidity "bear[ ] uncomfortable resemblance to an oligarch" that gives judges the final word.[112] Thus, originalism provides clear limitations on undemocratic actors, leaving "adequate space for democratic decision making."[113]

Though originalism purports to be apolitical, a closer look demonstrates that it is anything but. Originalism's foundational premise, that the Constitution must be interpreted based upon its original meaning when it was ratified, relies on the false hood that at ratification the Constitution's meaning was fixed.[114] Not so. Many compromises went into the Constitution's drafting—and that its drafters, ratifiers, and ultimately those who are governed by it, all come from different communities.[115] Just as the Constitution's meaning is contested today, it was contested in the past: Originalists begin their argument by declaring a winner in a contest over viewpoints. That is a political act.

Next examine whose interpretations are chosen. Recall Justice Scalia's position that "[t]he purpose of constitutional guarantees is precisely to prevent the law from reflecting certain changes in original values that the society adopting the Constitution thinks fundamentally undesirable."[116] It cannot be disputed whose notion of values are reflected in the "original" Constitution: that of the ruling class, or more narrowly, property-holding White men. Neither can it be disputed that today's ruling class and the original ruling class share an interest in protecting their place atop America's social hierarchy.

Evidence of this is present in Justice Scalia's *United States v. Virginia* dissent, which is largely committed to defending the original ruling class's definition of American identity. So much so, that he begins his dissent with an ode to the Framers that he deemed necessary "to

111. *Id.*
112. *Id.* at 664.
113. *Id.* at 665.
114. *Id.*
115. *Id.* at 666.
116. Scalia, *supra* note 110, at 162 (emphasis added).

counterbalance the Court's criticism of our ancestors."[117] "Since it is entirely clear," Justice Scalia proclaimed, "that the Constitution of the United States—the old one"[118] permitted single-sexed military academies, he concluded that the Court erred in holding that the Virginia Military Institute's admission policy that excluded women violated the Fourteenth Amendment.

To that I ask one question: would Harriett Tubman, a Union soldier, agree that the public meaning of "equal protection" barred her from a military academy because of her gender?[119] Or more broadly, would the Union Army that depended on her service, agree that the public meaning of "equal protection" barred Harriet Tubman from a military academy? Harriett Tubman, and other Black Union Army soldiers, were certainly capable of defining equal. They were also Framers of the Fourteenth Amendment and included in the public. Why doesn't Justice Scalia's perspective engage their viewpoints?

Finally, consider originalism's desire to entrench itself as the only legitimate interpretive method that is legitimately objective. It does not argue that Harriet Tubman and Andrew Johnson likely would have disagreed on "equal's" meaning, but Johnson receives deference as a member of the ruling class. Indeed, it ignores Tubman's perspective and instead asserts that Jackson's would be the only legitimate understanding. To originalists, originalism *is* the law.[120] That view, however, reduces America to "an assimilative, homogenous society," where the ruling class's values become the society's.[121]

The circular argument should not be accepted, originalism—and all methods of interpretation—should be understood first, and foremost, as a political framework. Then, it should be questioned as a political framework: namely, does this methodology serve the people that it governs. Its legitimacy must be rooted in whether it passes such scrutiny.

2. Intersectionality as Identity Politics

Just as originalism is an identity politic of the ruling class, the Combahee River Collective ("CRC"), a Black feminist organization,

117. *Virginia*, 518 U.S. at 567 (Scalia, J. dissenting).
118. *Id.*
119. Angela Davis, *Reflections on the Black Woman's Role in the Community of Slaves*, *in* WORDS OF FIRE: AN ANTHOLOGY OF AFRICAN-AMERICAN FEMINIST THOUGHT 200 (Beverly Guy-Sheftall, ed., 1995).
120. Jamal Greene, *On the Origins of Originalism*, 88 TEX. L. REV. 1, 74 (2009).
121. Michael H. v. Gerald D., 491 U.S. 110, 131 (1989) (Brennan, J. dissenting).

explains intersectionality as an identity politic of the oppressed.[122] In their canonical work, the CRC declared that "the most profound and potentially most radical politics come directly out of our own identity, as opposed to working to end somebody else's oppression."[123] Rejecting "pedestals" and "queenhood," the CRC sought "[t]o be recognized as human, levelly human," that was "enough."[124]

The CRC made clear that they identify as feminists and lesbians, therefore, "focusing upon [their] oppression is embodied in the concept of identity politics." They argued that under patriarchy, oppression based on their sex, class, and race was equally pervasive and inseparable because all three oppressions "are most often experienced simultaneously."[125]

Still, in developing their politic from their own oppression, the CRC did not reject solidarity with "progressive Black men" and rejected "the fractionalization that white women who are separatists demand."[126] They explained that they "struggle together with Black men against racism" and "with Black men about sexism."[127] Ultimately, they contend that "the liberation of all oppressed peoples necessitates the destruction of the political-economic systems of capitalism and imperialism as well as patriarchy."[128] And while being in "essential agreement with Marx's theory as applied to very specific economic relationships," they recognized that his analysis "must be extended further in order" to understand the specific economic situation of Black women.[129]

In short, the CRC initiated a resistance framework—it was dedicated to understanding the multifaceted impact of white supremacist rule, in order to defeat it. Intersectionality, as defined by the CRC, is thus the antithesis of originalism. A flat rejection of the Framers' imagination. In fact, it is an affirmation that the Framers are fundamentally wrong. And therefore, intersectionality as an identity politic is dedicated to creating a liberatory framework.

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122. Keeanga-Yamahtta Taylor, *Introduction*, *in* How We Get Free: Black Feminism and the Combahee River Collective 8 (Keeanga-Yamahtta Taylor ed., 2017).

123. Combahee River Collective, *The Combahee River Collective Statement*, *in* How We Get Free: Black Feminism and the Combahee River Collective 19 (Keeanga-Yamahtta Taylor ed., 2017).

124. *Id.*

125. *Id.*

126. *Id.*

127. *Id.*

128. *Id.*

129. *Id.* at 20.

The CRC's articulation of intersectionality was its "way of thinking about the problem of sameness and difference and its relation to power."[130] And while the CRC's use of intersectionality was rooted in their identity as Black feminist lesbians, intersectionality as a political framework recognizes that "identity is not a set of fixed attributes."[131] It understands that "identity is always a never-completed process of becoming" and "a constantly shifting process of positioning."[132] That is because the use of race-gender-class as the primary lens to understand power dynamics does not mean that the "concepts were confined to subordinated people."[133] Thus, there are an infinite number of combinations that permit for context-specific analysis of social issues and remedies.[134] The Framers, after all, had a race, gender, and class.

To best summarize intersectionality, let's focus on three of its six core tenants.[135] *First*, it emphasizes relationality—"the idea of interconnections, mutual engagement, and relationships."[136] As the CRC declares, "race, gender, class, and other systems of power are constituted and maintained through relational processes."[137] *Second*, it recognizes the importance of power.[138] "Intersecting power relations produce social divisions of race, gender, class, sexuality, ability, age, country of origin, and citizenship status," for example, and these systems of power "mutually construct one another by drawing upon similar and distinctive practices and forms of organization that collectively shape social reality."[139] *Third*, intersectionality is a rethinking of social inequality.[140] It rejects that inequality is "natural and inevitable," explaining that power relations produce the inequalities and "the social problems they engender."[141]

Note that intersectionality does not deify a particular group as rightful rulers. Nor does it suggest that there is a definitive answer to

130. PATRICIA HILL COLLINS, INTERSECTIONALITY AS CRITICAL SOCIAL THEORY 23 (2019).
131. *Id.* at 37.
132. *Id.*
133. *Id.* at 39.
134. *Id.* at 40.
135. The final three tenants are largely related to epistemology and intersectionality as a form of knowledge production in the academy. While important, those considerations exceed the scope of this article. *See id.* at 45–46.
136. *Id.* at 45.
137. *Id.*
138. *Id.* at 46.
139. *Id.*
140. *Id.*
141. *Id.*

every question. It requires inquiry into the problem, who is harmed, and on what basis the person is harmed.[142] Critical to the inquiry is that a person should not be harmed because they are a person.[143] It rejects the notion of a "natural" social hierarchy or any at all.[144] It shifts the perspective of "might is right," to recognizing that oppressed groups "have a vested interest in opposing the political domination that fosters their subordination."[145]

As an identity politic, intersectionality recognizes that every human has dignity. It privileges the community over the individual, permitting different identities to have conflicting principles or objectives while ensuring that there is not a universally dominant group. The Constitution can, and should, be interpreted to do the same.

III. INTERSECTIONALITY AS AN INTERPRETIVE METHOD

Unlike originalism, intersectionality has not been embraced by jurists as a method of constitutional interpretation. In fact, as Kimberlé Crenshaw explains, the American legal system employs a "single-issue" framework that is conceptually limited, and therefore, antithetical to intersectionality.[146] Hence, when Black women are harmed, they are forced "to choose between specifically articulating the intersectional aspects of their subordination."[147] Put another way, courts do not readily embrace harms based on race, gender, *and* class. Black women claimants are given a choice: pick one.

This "choice," of course, is insufficient. Crenshaw observes that where courts reject Black women's claims alleging discrimination based on race *and* sex, Black women "are protected only to the extent that their experiences" coincide with Black men or White women.[148] Where the harms do not coincide, Black women are left without a remedy.

But that's not all. Courts refusal to recognize intersectional harms "defeats efforts to restructure the distribution of opportunity and limits remedial relief to minor adjustments within an established

142. *Id.* at 83–84.
143. *Id.* at 84.
144. *Id.*
145. *Id.*
146. Kimberlé Crenshaw, *Demarginalizing the Intersection*, 139 U. CHI. LEGAL F. 139, 149 (1989).
147. *Id.* at 148.
148. *Id.* at 143.

hierarchy."[149] In other words, Crenshaw posits that if Black women's intersectional harms were recognized, intersectional remedies would follow—thus permitting collective gains amongst oppressed groups, e.g., Black men and White women.[150] To summarize, Crenshaw's thesis is that intersectionality is necessary for courts to adequately identify and define harms to Black women.

Some federal judges have applied Crenshaw's thesis. Take Judge Damon Keith, formerly of the Sixth Circuit. In *Rabidue v. Osceola Refining Co.*, Judge Keith's separate opinion provides an intersectional rule to determine when a woman has stated a hostile work environment claim under Title VII.[151] There, he asserted that courts should "adopt the perspective of the reasonable victim" when determining whether a work environment is hostile.[152] In doing so, it would allow "courts to consider salient sociological differences as well as shield employers from the neurotic complaint."[153] Without analyzing the environment from the perspective of a reasonable woman, Judge Keith explains, "the defendants as well as the courts are permitted to sustain ingrained notions of reasonable behavior fashioned by the offenders, in this case men."[154] This is seemingly a straightforward application of Crenshaw's thesis.

Central to Judge Keith's concurrence applying Crenshaw's thesis is that he analyzed the hostile work environment from the perspective of the plaintiff: a Black woman. In doing so, Judge Keith's opinion rejects what Crenshaw explained as the single-issue framework that operates to legalize Black women's subjugation. In fact, where judges consider Black woman's harms, yet continue to employ a single-issue framework, the result is likely to reinforce Black-woman-inferiority as a social and cultural norm.

Justice Thomas's concurrence in *Box v. Planned Parenthood* provides a stark example of the aforementioned issue.[155] In *Box*, the Court granted certiorari and reversed the Seventh Circuit's judgment that held that an Indiana law related to the disposition of fetal remains by abortion providers was irrational, while denying certiorari

149. *Id.* at 145.
150. *Id.*
151. 805 F.2d 611, 623 (Keith, J. concurring in part, dissenting in part).
152. *Id.* at 626.
153. *Id.* (citing Comment, *Sexual Harassment Claims of Abusive Work Environment Under Title VII*, 97 HARV. L. REV. 1449, 1451 (1984)).
154. *Id.*
155. *Box v. Planned Parenthood*, 139 S. Ct. 1780, 1782 (2019) (Thomas, J. concurring).

on the constitutionality of another provision of the law that barred sex-, race-, disability-selective abortions.[156] Justice Thomas's concurrence focused solely on the issue the Court did not address: the constitutionality of a law forbidding abortions based on the sex, race, or potential disability of the child.

Justice Thomas's analysis of the Indiana law is thought-provoking. "[T]his law and other laws like it promote a State's compelling interest in preventing abortion from becoming a tool of modern-day eugenics," it begins.[157] Modern eugenics, Justice Thomas continues, traces back to Planned Parenthood founder, Margaret Sanger's "birth control movement."[158] Sanger, Justice Thomas notes, acknowledged and embraced birth control as a form of eugenics.[159] And "[m]any eugenicists," he continues, "believed that the distinction between the fit and unfit could be drawn along racial lines."[160]

While Sanger rejected abortion, Justice Thomas contends that "Sanger's arguments about the eugenic value of birth control in securing 'the elimination of the unfit,' apply with even greater force to abortion, making it significantly more effective as a tool of eugenics."[161] What's more, Sanger with the assistance of Black ministers, and Black leaders like W.E.B. DuBois, "campaigned for birth control in [B]lack communities."[162] This all, Justice Thomas argues, stems from Sanger's foundational belief in preventing the "unfit" and "economically unable" from reproducing.[163] Perhaps most dangerously, Justice Thomas maintains that due to advances in technology, "abortion can now be used to eliminate children with unwanted characteristics."[164]

In telling a one-sided history, Justice Thomas's *Box* concurrence "provides a roadmap to lower courts and abortion opponents to challenge *Roe* on the grounds that the abortion right allegedly is rooted in racial injustice and results in disproportionate impacts on minority groups."[165] In this way, Justice Thomas exploits the Constitution's in-

156. *Id.* at 1782.
157. *Id.* at 1783.
158. *Id.*
159. *Id.*
160. *Id.* at 1785.
161. *Id.* at 1784.
162. *Id.* at 1788.
163. *Id.* at 1787–88.
164. *Id.*
165. Melissa Murray, *Race-Ing* Roe: *Reproductive Justice, Racial Justice, and the Battle for* Roe v. Wade, 134 HARV. L. REV. 2025, 2030 (2021).

consistent approach to women's rights. And notably, the *Box* concurrence does not opine on bodily autonomy. Rather, it asserts that the Constitution forbids eugenics, and to quell the modern-eugenics movement, States may pass laws that "protect" (Black) women's ability to reproduce.

In essence, Justice Thomas's argument turns intersectionalist arguments on their head.[166] As Melissa Murray explains, the Black community understood the importance of family planning.[167] Du Bois's endorsement of birth control was not to prevent unfit Black mothers from reproducing; it was in solidarity with Black women standing for their right to "choose motherhood at their own discretion."[168] That is not to say Justice Thomas's argument that race, abortion, and genocide are related is unfounded.[169] But by rebranding birth control as abortion, Justice Thomas ignores the perspective of Black women (the class his opinion purports to protect), mischaracterizes historical accounts, and ultimately promotes the erroneous single-issue framework.

Justice Thomas's *Box* concurrence also demonstrates the importance of identity politics and interpretive methods. By deploying an originalist methodology that ignores the perspective of Black women, Justice Thomas suggests that his stance against "eugenics" eradicates a harm and rejects Black women as socially inferior. The failure to engage Black women suggests that their belief that forced sterilization—not abortion—was the true genocidal threat, is unimportant.[170] And most importantly, it does not confront the strongest rebuttal: Black women "emphasized—and advocated for—[their] freedom and autonomy to use birth control voluntarily."[171] In effect, his *Box* concurrence reinforces the Framers' White-male-supremacist beliefs all while never mentioning them by name.

Still, *Rabidue* is just one opinion, Judge Keith is just one judge, and Kimberlé Crenshaw is just one scholar. *Rabidue*, as a Title VII

166. *See* DOROTHY ROBERTS, KILLING THE BLACK BODY: RACE, REPRODUCTION, AND THE MEANING OF LIBERTY 7 (1998) ("The greatest risk in writing a book about reproductive domination is that it will leave the *false* impression that Black women have been no more than passive puppets in a unidimensional plot to control their own actions.") (emphasis added).

167. Murray *supra* note 165, at 2040.

168. *Id.*

169. ANGELA Y. DAVIS, WOMEN, RACE & CLASS 213 (1983); *see also* ROBERTS *supra* note 166, at 81.

170. Murray *supra* note 165, at 2043.

171. *Id.* at 2043. Perhaps Margret Sanger's beliefs mattered more to Justice Thomas than the Black women he opined on.

case did not advance intersectionality as a constitutional interpretive theory, especially not one that would rival originalism. Pauli Murray, on the other hand, did use intersectionality as a method of constitutional interpretation. Hence, Murray's jurisprudence is a logical starting point for the next inquiry.

A. Constitutional Intersectionality According to Pauli

Pauli Murray's intersectionalist interpretive method revolves around a straightforward principle: "Your rights end where the other fellow's rights begin."[172] This belief undergirds her arguments that the equal protection clause forbids discrimination based on race, gender, and income. As Murray explains, her approach to interpreting the Fourteenth Amendment's Equal Protection Clause "was to enumerate the rights that affect the individual's personal status in the community, one of which is 'the right not to be marked with a badge of inferiority.'"[173]

Like the CRC, Murray connects intersectional identity politics to social change. In *The Negro Woman's Stake in the Equal Rights Amendment*, for example, Murray identifies the Constitution's intersectional flaws and advances an argument to fix them by ratifying the Equal Rights Amendment,[174] which, if ratified, would forbid sex-based discrimination.[175] "Negro women as a group have the most to gain from the adoption of the Equal Rights Amendment," Murray begins. That is because Black women have "been doubly victimized by the twin immoralities of racial and sexual bias" that are entrenched in legal distinctions and classifications.[176]

This "dual victimization," Murray contends, "creates special problems of educational disadvantage, lack of employment opportunities, low income, poverty, and general powerlessness."[177] In characterizing race and sex discrimination as "dual," Murray isolates the two forms of discrimination while acknowledging that the relationships are "close."[178] Thus, Black women are not necessarily one class, but

172. PAULI MURRAY, SONG IN A WEARY THROAT: AN AMERICAN PILGRIMAGE 528 (2018).
173. *Id.* at 293.
174. Pauli Murray, *The Negro Woman's Stake in the Equal Rights Amendment*, 6 HARV. C.R.-C.L. 253, 253 (1971).
175. *Equal Rights Amendment*, EQUAL RTS. AMEND., https://www.equalrightsamendment.org (last visited Feb. 10, 2022).
176. Murray *supra* note 174, at 253.
177. *Id.* at 256.
178. *Id.* at 257.

rather *two* classes—Black and women—and those two classes are "comparable."[179] In like manner, "[b]oth classes have been defined by, and subordinated to, the same power group—white males."[180]

With that in mind, "the adoption of the Equal Rights Amendment would have certain advantages for [B]lack women not realizable by other means."[181] Legally, it would recognize equal rights that were unrecognized "under the Civil War Amendments,"[182] and consequently, provide "broader protections than the [F]ourteenth amendment" because it would apply to both the federal government and the States.[183] Murray further argues that the Equal Rights Amendment would benefit Black women psychologically and educationally by enlarging Black women's "political influence."[184] In turn, the Equal Rights Amendment's ratification "strikes a blow at the powerlessness which all women share, but which Negro women experience in intensified form."[185] The Amendment, would "enable women to achieve equal power with men in societal decision-making," namely in "formal authority structures and policy-making processes" like legislatures and the courts.[186] This change not only improves democracy but "would be an important step toward a new era of human relations."[187]

Though the Equal Rights Amendment has yet to be ratified, beginning with the Court's decision in *Reed v. Reed*,[188] and culminating in *United States v. Virginia*, Murray's argument for the Equal Rights Amendment has largely been adopted. Yet, intersectionality, as Crenshaw explains, remains largely unrecognized. Why?

Central to Murray's intersectional analysis is the race-sex parallel. In short, Murray argues that any notion of supremacy reinforced by law, whether based on race or sex, is equally harmful. Pre-*Brown*, Murray argued that "the separate-but-equal doctrine violated the

179. *Id.*
180. *Id.*
181. *Id.* at 258.
182. *Id.*
183. *Id.* at 259.
184. *Id.*
185. *Id.*
186. *Id.*
187. *Id.*
188. 404 U.S. 71 (1971). Here, the Court adopts lawyer-Ruth Bader Ginsburg's argument that the Fourteenth Amendment forbids sex-discrimination. Ginsburg famously credits Murray as one of the brief's authors. *See* Olivia B. Waxman, *In Previously Unseen Interview, Ruth Bader Ginsburg Shares How Legal Pioneer Pauli Murray Shaped Her Work on Sex Discrimination*, TIME, https://time.com/5896410/ruth-bader-ginsburg-pauli-murray/(last updated Oct. 16, 2020, 5:54 PM).

right of Negro children 'not to be set aside or marked with a badge of inferiority.'"[189] Thus, once the Court recognized Murray's argument in *Brown*, Murray applied the same reasoning to sex because both subordinations were "predicated upon supposedly inherent differences."[190]

Though the *Reed* and *Brown* Courts adopted Murray's conclusion, its post-*Brown* race-doctrine greatly differs from its post-*Reed* sex doctrine. Namely, the Court evaluates Fourteenth Amendment race-claims and sex-claims under different tiers of scrutiny. This significant difference in tiers-of-scrutiny is the logical outcome of the Court's failure to engage Murray's intersectionalist analysis. Let's examine the Court's single-factor analysis, then engage the intersectionalist improvement.

1. The Race Framework

Any use of race, the Court held in *Adarand Constructors, Inc. v. Peña*, is subject to "the strictest judicial scrutiny."[191] That is because "classification[s] based upon [a] racial or ethnic background . . . impinge upon personal rights."[192] In other words, the Court reasons that any law that includes a racial classification, no matter its purpose and no matter the classification, places a burden on an individual.[193] Or, as Chief Justice Roberts explained in *Parents Involved*, which held that public school districts cannot consider race to prevent school segregation: "The way to stop discrimination on the basis of race is to stop discriminating on the basis of race."[194]

Since *Adarand*, the Court has embraced a straightforward position: race, not white supremacy, is harmful. This development is the logical outcome of the Court's general failure to interrogate and eradicate *Dred Scott*'s racial underpinnings. Begin with Justice Harlan's famous *Plessy v. Ferguson* dissent.[195] Though it foresaw that the majority's opinion would prove to be "quite as pernicious" as *Dred Scott*, it did not attack *Plessy*'s and *Dred Scott*'s fundamental flaw—white

189. SERENA MAYERI, REASONING FROM RACE: FEMINISM, LAW, AND THE CIVIL RIGHTS REVOLUTION 16 (2011).
190. *Id.* at 17.
191. 515 U.S. 200, 224 (1995).
192. *Id.*
193. *Id.* (quoting Regents of Univ. of Cal. v. Bakke, 438 U.S. 265, 289–90 (1978)) (Powell, J. plurality).
194. Parents Involved in Comm. Schs. v. Seattle Sch. Dist. No. 1., 551 U.S. 701, 748 (2007).
195. Plessy v. Ferguson, 163 U.S. 537, 559 (Harlan, J. dissenting).

supremacy.[196] In fact, his often-cited observation that "our constitution is color-blind, and neither knows nor tolerates class among citizens"[197] is preceded by an endorsement of white supremacy. "The [W]hite race deems itself to be the dominant race in this country," Justice Harlan began.[198] "And so it is, in prestige, in achievements, in education, in wealth, and in power. So, I doubt not, it will continue to be for all time, if it remains true to its great heritage, and holds fast to the principles of constitutional liberty,"[199] he concluded. In other words, Justice Harlan drew a line—societal beliefs of racial superiority and inferiority are legitimate, but the law is not to endorse them. "In the eye of the law, there is no superior, dominant ruling class of citizens," indeed our Constitution is colorblind.[200]

In adopting much of the reasoning in Justice Harlan's *Plessy* dissent, the *Brown* majority also conflated "race" with white supremacy. Indeed, *Brown* reasoned that segregation "is usually interpreted as denoting the inferiority of the negro group,"[201] and consequently, it tended to "(retard) the educational and mental development of Negro children and to deprive them of some of the benefits they would receive in a racial(ly) integrated school."[202] Yet *Brown* ignored that White children were also deprived of the benefits of an integrated school.[203] If, as *Brown* posits, education was "perhaps the most important function of state and local governments," and the "very foundation of good citizenship,"[204] weren't the segregators' children the *most* deprived of the necessary education? The segregated public schools indoctrinated White children in the lie of their superiority. Accordingly, they were being developed into bad citizens, while Black students were denied full citizenship.

196. *Id.*

197. *Id.*

198. *Id.* at 559.

199. *Id.*

200. *Id.*

201. Brown v. Board of Educ., 347 U.S. 483, 494 (1954).

202. *Id.*

203. *See also* Missouri v. Jenkins, 515 U.S. 70, 114 (Thomas, J. concurring). Justice Thomas's *Jenkins* concurrence begins with a bang: "It never ceases to amaze me that the courts are so willing to assume that anything that is predominantly [B]lack must be inferior." *Id.* Then, he takes an implicit shot at *Brown*, "the court has read our cases to support the theory that [B]lack students suffer an unspecified psychological harm from segregation that retards their mental and educational development." *Id.* This approach, Justice Thomas posits, "rests on an assumption of [B]lack inferiority." *Id.*

204. *Brown*, 347 U.S. at 493.

This is to say that while *Brown* signified a new era in race-based equal protection claims, it is the conclusions that changed more than the problematic analytical frames. And the modern analytical conclusion—race is bad—is oversimplistic and wrong. Rather than engage *Plessy*'s position that "[l]egislation is powerless to eradicate racial instincts or abolish distinctions based upon physical differences,"[205] *Brown* charted a new path. But the new path should not have been an attempt to "abolish distinction," rather it should have taken on *Plessy*'s implied thesis: "[L]egislation is powerless to eradicate white supremacy." This misstep may explain Derrick Bell's suggestion that though *Brown* was necessary, it has "proved of greater value to [W]hites than [B]lacks."[206] It also rationalizes Chief Justice Roberts's simplistic quip in *Parents Involved*.[207]

2. The Sex Framework

The Court's approach to sex-claims under the Equal Protection varies greatly from similar claims based on race. Principally, it has isolated male-supremacy as the harm, not sex as a classifier. In *United States v. Virginia*,[208] Justice Ginsburg's majority opinion began with identifying male-supremacy as the harm: "Through a century plus three decades and more, women did not count among voters composing 'We the People.'"[209] Making matters worse, "for a half century thereafter, it remained the prevailing doctrine that government, both federal and state, could withhold women opportunities accorded to men so long as any 'basis in reason' could be conceived for the discrimination," the opinion continues.[210]

VMI, however, rejected universalizing sex in the way that *Adarand* universalized race. Rather, it acknowledged "inherent differences" between "men and women," but uniformly rebuked difference as a pretext to "denigrat[e]" or "place artificial constraints on an

205. *Plessy*, 163 U.S. at 551.

206. DERRICK BELL RACE, RACISM, AND AMERICAN LAW, 105 (Vicki Been et. al. eds., 6th ed. 2008).

207. *But see* Schuette v. BAMN, 572 U.S. 291, 337 (2014) (Sotomayor, J. dissenting). In dissent, Justice Sotomayor offers a sharp critique of the majority's analysis, much of which relies on Chief Justice Roberts's premises in *Parents Involved*.

208. 518 U.S. 515 (1996). At issue here is Virginia Military Institute, a State school, for clarity I will identify the case as VMI going forward.

209. *Id.* at 531. Interestingly, Justice Ginsburg cites Thomas Jefferson for this proposition, *see id.* at n.5.

210. *Id.*

individual's opportunity."[211] And therefore, any law that "closes a door or denies opportunity" based on gender "reveals a strong presumption of unconstitutionality."[212] That presumption may be rebutted upon an "exceedingly persuasive" justification for the differential treatment.[213] In addition, the "justification must be genuine, not hypothesized . . . it must not rely on overbroad generalizations about the different talents, capacities, or preferences of males and females."[214] If the State meets the demanding burden imposed on a justification, it must "show at least that the challenged classification serves important governmental objectives and that the discriminatory means employed are substantially related to the achievement of those objectives."[215]

VMI thus affirms Murray's argument that the law harms when it stigmatizes *not* when it classifies. Unlike *Brown*, *VMI* attacked the underlying supremacist idea on its merits, then rejects it. Further, *VMI* applied "equal" broadly to mean opportunity, whereas *Brown* applied "equal" narrowly to mean integration into White schools. The key difference is that *Brown* assumed that the White schools were both better *and* objectively good—therefore, Black students were harmed because they were denied access. *VMI*, on the other hand, focused on the State's reliance on a presumption of women's inferiority to justify denial from a State program. Said differently, *VMI* finds sex-based stigma in the justification for segregation, whereas *Brown* only concludes that race, not white supremacy, is the justification for segregation.

3. The Limitations of Parallel Reasoning for Intersecting Issues

Put together, a constitutional intersectional race-sex claim is defunct because the different tiers of scrutiny make it virtually impossible to analyze the claim under a coherent framework. Still, that does not fully explain Crenshaw's point because she analyzed intersectionality under Title VII, which does not have tiers of scrutiny. Further, even under a constitutional standard, Black women should theoretically benefit by being able to bring sex-claims. At least that is what Murray argued when advocating for the Equal Rights Amendment. That, of course, has not occurred. Why not?

211. *Id.* at 533.
212. *Id.*
213. *Id.*
214. *Id.*
215. *Id.* (internal quotations omitted).

Well, to be terse, parallel frames do not intersect. Murray strategically universalized sex and race, respectively, arguing that both, independently, harm Black women. On that basis, Murray's theory is that *Black women are the intersection* of two independent frames. This overlooks that the *systems are intersecting*. Meaning, race, sex, and class intersect as oppressive structures, not because they independently "hit" Black women.

This distinction is explained in Angela Davis's *Women, Race, and Class*. There, Davis begins her intersectional inquiry by analyzing the plight of enslaved Black women. "The slave system defined Black people as chattel," Davis explains.[216] Women and men alike were "genderless as far as the slaveholders were concerned."[217] That is not to say that sex-based harms were non-existent. "Expediency governed the slaveholders' posture toward female slaves," meaning in some cases enslavers exploited Black women "as if they were men," which de-gendered them.[218] "[B]ut when [Black women] could be exploited, punished and repressed in ways only suited for women, they were locked into their exclusively female roles."[219]

Though the Reconstruction Amendments abolished chattel slavery and represented a "new founding," they did not abolish the intersectional system of oppression. In fact, the opposite occurred. In the early-1900s, Davis explains, "sexism and racism [were] mutually strengthening."[220] Black male suffrage was not, as some White women argued, a "favor[ing] of Black males over White females."[221] Rather, it "was a tactical move designed to ensure political hegemony of the Republican party in the chaotic postwar South."[222]

Davis's histography of the 19th Amendment's ratification further explains the sustained intersectional oppression that uniquely targeted Black women. This movement's roots, Davis explains, accompanied the labor movement because securing the ballot also secured women "equal place and equal wages in the world of work."[223] With the ballot, the argument went, working-class women would have the political power to "remove all those legislators from office whose loyalties

216. DAVIS *supra* note 169, at 5.
217. *Id.*
218. *Id.* at 6.
219. *Id.*
220. *Id.* at 122.
221. *Id.* at 74.
222. *Id.*
223. *Id.* at 138.

were with big business."[224] Further, W.E.B. DuBois supported Black women's suffrage not simply because of his socialist leanings, but also because it would double the Black community's "vote and voice in the nation" leading to a "stronger and more normal political life."[225] In theory, such a broad benefit would disrupt the patriarchal-capitalist-white supremacist social hierarchy.[226]

Yet, "[a]fter the long-awaited victory of woman suffrage, Black women in the South were violently prevented from exercising their newly acquired right."[227] This targeted suppression broadly impacted racial, gender, *and* class movements: conjunctively. As bell hooks explains the conjunctive oppression turns race, gender, and class into *adjectives*—descriptors of a unified system.[228] They are not nouns, as Murray argued, that name three individual systems; naturally, each group has a particularized experience.[229]

This is not to suggest that the oppressive system does not attack Black men or White women similarly. As Murray aptly demonstrated, it did. But similarly, is not the same. And time has since shown that interpretive framework must consider Black women's experiences independently.

This observation is not to minimize Murray's accomplishments. To be clear, reasoning through the race-sex parallel is great lawyering. And no one can contest that Murray was anything less than a great lawyer.[230] And thanks to Murray's lawyering, today the frames are better developed and, consequently, permit conjunctive analysis. Pre-Murray women, regardless of race or class, had *no* protection under the Fourteenth Amendment's Equal Protection Clause, making it impossible to build an intersecting framework. Hence, the point is to demonstrate that Murray's work provides a framework that should be expanded today.

B. Intersectional Constitutionalism Post-Murray

Using the CRC's intersectionalist identity political foundation, here I propose an intersectional interpretive method that recognizes

224. *Id.* at 143.
225. *Id.* at 146.
226. bell hooks, *Black Women: Shaping Feminist Theory*, *in* WORDS OF FIRE: AN ANTHOLOGY OF AFRICAN-AMERICAN FEMINIST THOUGHT 272 (Beverly Guy-Sheftall, ed.).
227. DAVIS, *supra* note 169, at 148.
228. hooks *supra* note 226, at 272–73.
229. *Id.* at 278.
230. Certainly not a 3L taking a class exploring Murray's jurisprudence.

different identity groups can, will, and should build their own liberatory models of constitutional interpretation. My proposal is not any group's identity politic, but rather one that will be able to weigh the claims brought by different identity groups and resolve claims fairly. To demonstrate the framework's utility, I apply it to abortions as a comparison to Justice Thomas's analysis in his *Box* concurrence.

Let's begin with three foundational principles. Up first: the text. The words, explicitly and implicitly, identify rights and provide limiting principles where necessary. Because there is often ambiguity we then acknowledge: (1) that the Constitution fundamentally protects human rights; (2) it accepts that human rights are responsive to identity, which is dynamic, not fixed; and (3) the legislative process may not be manipulated to deprive a group of a human right.[231]

Second, history—the People's history—matters. As the Court explained in *Planned Parenthood v. Casey*, "The proper focus of constitutional inquiry is the group for whom the law is a restriction, not the group for whom the law is irrelevant."[232] Meaning, we ask a simple question: what are the historical events and narratives that undermine or support the aggrieved group's argument that the Constitution protects this human right?

This approach recognizes that there are competing histories. As Howard Zinn explains, history is framed by conflict, there is a "world of victims and executioners" and thinking people need "not be on the side of the executioners."[233] Therefore, it is important to learn history from multiple perspectives, accept that because "the lines are not always clear" there are often multiple victims.[234] This approach rejects any attempt to quantify or rank human oppressions, but permits "[e]ach group [to] speak[ ] from its own standpoint and share[ ] its own partial, situated knowledge."[235] In considering multiple histories it is clear that giving deference to a singular history is not only incomplete but is also incorrect. As Zinn summarizes, "The cry of the poor is not always just, but if you don't listen to it, you will never know what justice is."[236]

231. This may result in an "expansion" of the Thirteenth Amendment or the Fourteenth Amendment's privileges and immunities clause.

232. Planned Parenthood v. Casey, 505 U.S. 833, 894 (1992).

233. ZINN, *supra* note 58, at 10.

234. *Id.*

235. PATRICIA HILL COLLINS, BLACK FEMINIST THOUGHT: KNOWLEDGE, CONSCIOUSNESS, AND THE POLITICS OF EMPOWERMENT 270 (1991).

236. ZINN *supra* note 58, at 10.

Third, we take tradition into account. Key to this inquiry are the values that undergird the right, and the subsequent value of rejecting or protecting the right. Thus, history contextualizes tradition. If there is a tradition of affirming or denying a right on racist, patriarchal, or capitalist grounds, then we treat that tradition as constitutionally suspicious. But if affirming or denying the right is essential to rejecting "natural hierarchies," then it is more likely that it is constitutionally protected.

To test this framework, let's apply it to counter Justice Thomas's *Box* concurrence where he argues against a constitutional right to abortion. Many people have argued that there are at least six textual roots recognize this right: (1) Article IV's Privileges and Immunities Clause,[237] (2) the Ninth Amendment, which provides that the Constitution protects unenumerated rights,[238] (3) the Thirteenth Amendment, which abolishes all badges and incidents of slavery,[239] the Fourteenth Amendment's[240] (4) Privileges and Immunities Clause,[241] (5) Due Process Clause,[242] and (6) Equal Protection Clause.[243]

Still, none of these amendments explicitly use the word "abortion," therefore, we look to the history and tradition of abortion specifically, and reproductive rights, generally. With respect to the Thirteenth Amendment, history would focus on the regulation of reproductive rights and its maintenance in upholding chattel enslavement.[244] Regarding the other textual arguments, the history and tradition would similarly focus on the relationship between the clause's text and the history and tradition of regulating reproductive rights. Still, my goal here is to explore the general intersectionalist framework that frames the argument, not make the specific argument under one of the aforementioned clauses.

Dred Scott provides some insight into a historical and traditional analysis. Its position that Black people were "beings of an inferior

237. U.S. CONST. art. IV; *see also* Richard H. Fallon, Jr., *If Roe Were Overruled: Abortion and the Constitution in a Post-Roe World*, 51 ST. LOUIS U. L.J. 611, 635 (2007).

238. U.S. CONST. amend IX.; *see also* Joseph F. Kadlec, Note, *Employing the Ninth Amendment to Supplement Substantive Due Process: Recognizing the History of the Ninth Amendment and the Existence of Nonfundamental Unenumerated Rights*, 40 B.C.L. REV. 387 (2007).

239. U.S. CONST. amend XIII; *see also* Laura Sjoberg, *Where are the Grounds for the Legality of Abortion? A 13th Amendment Argument*, 17 CARDOZO J.L. & GENDER 527 (2011).

240. *See generally* David H. Gans, *The Unitary Fourteenth Amendment*, 56 EMORY L.J. 907 (2007).

241. U.S. CONST. amend XIV.

242. *Id.*

243. *Id.*

244. *See* ROBERTS *supra* note 166, at 304–05.

order, and altogether unfit to associate with the white race, either in social or political relations; and so far inferior, that they had no rights which the [W]hite man was bound to respect"[245] made no reference to abortion, specifically, or reproduction, generally. But look closer. As Dorothy Roberts explains, this denial of Black humanity was also a manifestation of a "degrading mythology about Black mothers."[246] Indeed, "preserving racial distinctions required policing reproduction," therefore, "it is only natural that Black mothers [were and are] a key focus of this racist ideology."[247] Black mothers, after all, "transmit inferior physical traits to the product of conception their genes."[248]

Black women's reproductive autonomy was also denied on legal and economic grounds. Indeed, one of chattel enslavement's core evils was that children were the property of the enslaver, this, of course, was codified into law.[249] As Thomas Jefferson explained, "I consider a woman who brings a child every two years as more profitable than the best man on the farm what she produces is an addition to the capital, while his labors disappear in mere consumption."[250] In some ways, Black reproduction was forced, and thus repurposed as a form of subjugation, "[i]t marked Black women from the beginning as objects whose decisions about reproduction should be subject to social regulation rather than to their own will."[251] Abortions, therefore, became an act of self-determination *and* resistance to the chattel enslavement system.[252]

Even after chattel enslavement's abolition, Black women's subjugation through the loss of reproductive freedom persisted. Most notable is the well-documented history of forced sterilization. During the 1960s, for example, many state legislatures attempted to pass laws ordering single mothers, most of whom were Black, to be sterilized.[253] And though those attempts failed, that did not prevent doctors from

245. *Dred Scott*, 60 U.S. at 407.
246. ROBERTS *supra* note 166, at 8.
247. *Id.* at 9.
248. *Id.*
249. A. LEON HIGGINBOTHAM, JR., IN THE MATTER OF COLOR: RACE AND THE AMERICAN LEGAL PROCESS 42–45 (1978).
250. Alexander Ingrassia, *Jefferson as Slave Master: A View from the Letters (1)*, THE JEFFERSON – HEMINGS CONTROVERSY, http://digital.lib.lehigh.edu/trial/jefferson/episodes/list/1_6_11.
251. ROBERTS *supra* note 166, at 23.
252. *Id.* at 46.
253. *Id.* at 94.

performing unconsented-to and unnecessary hysterectomies on Black women.[254] Nor did it prevent the widespread performance of involuntary sterilizations on institutionalized Black women and men, alike.[255]

While abortion-bans and forced sterilization have opposite results, they are share an oppressive foundation: the State's control of reproductive rights. As Frances Beal, the head of the Student Nonviolent Coordinating Committee's Black Liberation sub-committee, explained, "Black women have the right and responsibility to determine when it is in the interest of the struggle to have children or not to have them and this right must not be relinquished to any . . . to determine when it is in her own best interests to have children."[256] Indeed, government control of procreation historically and traditionally has cut at "the heart of what it means to be human."[257] Thus, protecting a woman's decision to bear a child "is a necessary ingredient of a community that affirms the personhood of all its members."[258] This history would require an intersectionalist judge to reject any abortion ban absent the State's showing that the law did not uphold or promote this history and tradition of social inferiority *and* that the ban was the *only* way it could satisfy a compelling interest.

Undoubtedly, the intersectionalist approach erects high bar for the State to clear and likely strips a legislature of their ability to regulate abortions. Assume that a State has a fair election, and the legislature passes a law outlawing abortion, the intersectionalist approach seemingly contravenes the democratic will of the People. This is the precise issue that Bickel warns of and cautions that courts should avoid.[259] In a democracy, don't citizens have a right to determine what values best reflect the society they want to live in?

True enough: citizens have a right to use the legislative process to govern in accordance with their values. The purpose of constitutional rights, however, is to prevent majoritarian tyranny. The deprivation of a human right is not a value that the Constitution should respect. And Murray's own words provide the intersectionalist judge with a prepackaged response for anyone—including originalists—that would suggest otherwise. Indeed, if the Constitution is intended to truly pro-

254. *Id.* at 90.
255. *Id.* at 89.
256. *Id.* at 100.
257. *Id.* at 305.
258. *Id.* at 311.
259. *Infra* 5–6.

tect *all* "the People," one person's rights must end where the other fellow's rights begin."[260]

IV. CONCLUSION

In 1971, the same year future-Justice Ginsburg argued *Reed v. Reed* relying on many of Pauli Murray's arguments,[261] Murray wrote a letter to then-President Richard Nixon. The letter, which Murray admitted was the "kookiest idea in the world," informed Nixon that Murray was interested in filling one of the two vacancies on the Supreme Court.[262] Unsurprisingly, Nixon rejected Murray's offer and did not appoint the first Black woman to the Supreme Court.[263] But it is unlikely that Murray truly wanted the job. The goal, Murray acknowledged, was to "stir discussion about the lack of a woman on the court."[264]

Perhaps Murray's decision to stir the discussion worked. A little less than a decade later, while campaigning for president, Ronald Reagan pledged to appoint the first woman to the Supreme Court.[265] He, like Murray, recognized that the federal courts were imbalanced.[266] But unlike Murray, Reagan opposed the Equal Rights Amendment, and unsurprisingly, his pledge raised questions about the motivations undergirding his search for a woman justice.[267] Nonetheless, he upheld the promise with the appointment of Justice Sandra Day O'Connor.

Since Justice O'Connor's appointment and confirmation, there have been four other women justices on the Nation's high court. None are Black women. On the campaign trail, Joe Biden—similarly

260. Murray *supra* note 174, at 528.

261. *See* Julie C. Suk, *A Dangerous Imbalance: Pauli Murray's Equal Rights Amendment and the Path to Equal Power*, 107 VA. L. REV. ONLINE 3, 5 (2021).

262. Eleanor Blau, *63 and an Activist, She Hopes to Become an Episcopal Priest*, N.Y. TIMES (Feb. 11, 1974), https://www.nytimes.com/1974/02/11/archives/63-and-an-activist-she-hopes-to-become-an-episcopal-priest.html.

263. Publicly, Murray used she-her pronouns and identified as a woman. Murray's private papers demonstrate that Murray sought male hormones and may have been non-binary or trans. *See* SERENA MAYERI, REASONING FROM RACE: FEMINISM, LAW, AND THE CIVIL RIGHTS REVOLUTION 16 (2011) (documenting that Murray had private struggles concerning her gender identity and sought male hormones).

264. Blau, *supra* note 262.

265. Lou Cannon, *Reagan Pledges He Would Name a Woman to the Supreme Court*, WASH. POST (Oct. 15, 1980), https://www.washingtonpost.com/archive/politics/1980/10/15/reagan-pledges-he-would-name-a-woman-to-the-supreme-court/844817dc-27aa-4f5d-8e4f-0ab3a5e76865/?itid=LK_inline_manual_18

266. *Id.*

267. *Id.*

to Reagan—took note of history and pledged to change that.[268] Now as President, Joe Biden has since doubled down on his pledge, making clear that he will appoint a Black woman to replace Justice Breyer who intends to retire at the end of the 2021 Term.[269] The key question, of course, is who.

As always, much of the discourse surrounding who will be the first Black woman justice has focused on the candidate's "qualifications."[270] But what makes a person "qualified"? To Murray, "a qualified woman justice would have special insight to the problems of women."[271] "[I]t wouldn't do any good for the president to appoint unqualified women or conservative women who are insensitive to the problems of women in our society," Murray continued.[272]

The contemporary discourse largely tracks Murray's 1971 opinion. South Carolina Congressman Jim Clyburn, for example, has advocated for a nominee with a "diversity of experience" so that the Democratic Party is not branded as elitist.[273] Other Democratic Party members have focused on finding a Black woman with an "impeccable resume."[274] It thus appears that the ideal Black woman nominee will have some combination of elite education and diverse work experience. Someone like . . . well, Pauli Murray.

Still, most of the discussions concerning qualifications, would not have captured Murray's genius. That is because Murray's impact is more about what she believed, not simply what she accomplished. Said differently, Murray's accomplishments are a manifestation of what she believed. Murray imagined both a better world and Constitution than what she experienced and Murray's genius manifests

268. Debra Cassens Weis, *Biden Has Pledged to Nominate a Black Female SCOTUS Justice—Who Are the Possibilities?*, AM. BAR ASS'N J. (Nov. 9, 2020, 12:59 PM), https://www.abajournal.com/news/article/biden-has-pledged-to-nominate-a-black-female-justice.-who-are-the-possibilities.

269. Eli Stokols, *Biden Vows to Appoint a Black Woman to the Supreme Court as Breyer Makes Retirement Official*, L.A. TIMES (Jan. 27, 2022, 2:06 PM), https://www.latimes.com/politics/story/2022-01-27/biden-embraces-supreme-court-vacancy-as-breyer.

270. Michael D. Shear & Charlie Savage, *Biden Expected to Nominate a Black Woman to the Supreme Court*, N.Y. TIMES (Jan. 27, 2022, 10:39 AM), https://www.nytimes.com/2022/01/26/us/politics/supreme-court-nominee-black-woman.html.

271. Jeyee Heard, *Woman Law Professor Asks for Court Seat*, HARVARD CRIMSON (Sept. 28, 1971), https://www.thecrimson.com/article/1971/9/28/woman-law-professor-asks-for-court/.

272. *Id.*

273. Jonathan Martin, *How Democrats Are Already Maneuvering to Shape Biden's First Supreme Court Pick*, N.Y. TIMES (June 14, 2021), https://www.nytimes.com/2021/02/21/us/politics/biden-supreme-court-black-woman.html.

274. *Id.*

through her ability to evolve imagination into a political ideology and that political ideology into jurisprudence.

True enough, asking the first Black woman justice to "be" Pauli Murray is not only unfair—it is impossible. But that does not mean we cannot ensure that the first Black woman justice engages Murray's legacy. In fact, such an ask is supported by precedent.

Shortly after Justice Thomas's confirmation, Judge A. Leon Higginbothoam, formerly the Third Circuit's Chief Judge, wrote him an open letter. "When I think of your appointment to the Supreme Court," Judge Higginbotham writes, "I see not only the result of your own ambition, but also the culmination of years of heartbreaking work by thousands who proceeded you."[275] He then warns, "I know you may not want to be burdened by the memory of their sacrifices. But I also know that you have no right to forget that history."[276]

While Judge Higginbotham's tone evinces larger frustrations with Justice Thomas's past comments regarding the Civil Rights Movement and affirmative action,[277] the substance applies to any Black jurist. Individual gains, as Justice Higginbotham explains, are the result of collective struggle. And though the responsibility of respecting history, even for the well-intentioned, can be daunting largely because "solidarity," "respect," and "responsibility" vary greatly,[278] Judge Higginbotham's request is simple. Remember the struggle. Engage the struggle. And ultimately, further the struggle.

Thus, as we await the first Black woman justice, I hope that she is moved by the substance of Judge Higginbotham's message. That she cherishes the "years of heartbreaking work by thousands" who preceded her. That she embraces the history that led to her appointment and proudly carries its force.[279] And ultimately, like Pauli Murray, she imagines freedom that does not yet exist.

275. A. L. Higginbotham Jr., *Open Letter to Justice Clarence Thomas from a Federal Judicial Colleague*, 140 U. PA. L. REV. 1005, 1007 (1992).
276. *Id.* at 1015–20.
277. *Id.* at 1007.
278. *See, e.g.*, Tommie Shelby, *Foundations of Black Solidarity: Collective Identity or Common Oppression*, 112 ETHICS 231 (2002).
279. Higginbotham *supra* note 275, at 1007.