UN-ERASING RACE IN A MEDICAL-LEGAL PARTNERSHIP: ANTIRACIST HEALTH JUSTICE ADVOCACY BY DESIGN

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[I]t is only by naming racism, asking the question "How is racism operating here?" and then mobilizing with others to actually confront the system and dismantle it that we can have any significant or lasting impacts on the pervasive "racial" health disparities that have plagued this country for centuries.

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1. Dina Shek, *Centering Race at the Medical-Legal Partnership in Hawai'i*, 10 U. MIAMI RACE & SOC. JUST. L. REV. 109, 112 n.14 (2019) (*quoting* Camara Phyllis Jones, *Confronting Institutionalized Racism*, PHYLON 7, 7 (2003)).

ABSTRACT

This Article covers a potential response to a Massachusetts state law which has been interpreted to require health care providers and birthing hospitals to report to state authorities any infant born to a person taking medication of opioid use disorder. While the statute mandates reports where a professional has "reasonable cause to believe that a child is suffering physical or emotional injury" as a result of substance dependence at birth, the Article highlights that many institutions report all infants born to persons with substance abuse disorders, regardless of risk of harm, for fear of penalty for failure to report. As a result, many individuals endure months or years long involvement with state authorities without warrant. Many patients avoid necessary pre- and perinatal care, addiction treatment, or both for fear of repercussions. Importantly, the Authors note that these challenges have been disproportionately impacting the Black community. As a potential solution, the Authors explore the possibility of an academic medical legal partnership which would support patients of a regional referral center and medical home for the treatment of substance use disorder in pregnancy. The Authors advocate for the use of such partnerships across different communities. Furthermore, they claim that academic medical legal partnerships which utilize an antiracist design can 1) shift the dialogue regarding social determinants of health and 2) fulfill ABA curriculum standards in law schools.

INTRODUCTION

Just before COVID-19 began to overwhelm the United States, a physician came to some law clinic teachers with a problem related to another epidemic altogether. State law, Dr. Saia explained, was commonly interpreted to require health care providers and birthing hospitals to report to state authorities any baby born to a person taking prescribed medications for opioid use disorder ("MOUD").[2] The relevant Massachusetts statute reads:

2. Abbreviated MOUD, medication for opioid use disorder treatment (previously known as "medication-assisted treatment" or "MAT") includes treatments such as methadone. *See, e.g.*, *Medication Assisted Treatment*, U.S. DEP'T OF HEALTH & HUM. SERVS.: SUBSTANCE ABUSE AND MENTAL HEALTH SERVS. ADMIN., (July 25, 2022), https://www.samhsa.gov/medication-assisted-

> "A mandated reporter who, in his [*sic*] professional capacity, has reasonable cause to believe that a child is suffering physical or emotional injury resulting from . . . physical dependence upon an addictive drug at birth, shall immediately communicate with the [D]epartment [of Child & Family Services] orally and, within 48 hours, shall file a written report with the department detailing the suspected abuse or neglect . . .[3]"

Even at institutions that interpret the statutory language in less absolute terms, Dr. Saia explained, many health care providers fear threats to their professional licensure if they do not report babies born to people with substance use disorders ("SUDs"), including those receiving the evidence-based standard of care for opioid use disorder ("OUD"), regardless of whether the child is at risk of harm. As a result of both the law and societal stigma associated with addiction, many patients (and similarly situated people around the state) were becoming unnecessarily entangled in months- or years-long involvement with Massachusetts authorities, placing stress on their recoveries. Sometimes, unwarranted involvement still led to removing children from their birth parent(s), with demonstrated serious effects on both recovering parents and child health and development. Many potential patients went without pre- and perinatal care, addiction treatment, or both. This largely resulted from fear of becoming caught up in family regulation and/or penal systems or out of mistrust of the medical system.[4] Importantly, the doctor explained, comparing her clinic's patient demographics with the hospital's overall patient population, she and her colleagues inferred that these potential patients' forgoing treatment were disproportionately Black.[5]

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treatment [https://perma.cc/57CE-A8RX].

3. MASS. GEN. LAWS ch. 119, § 51A(a) (2020), https://malegislature.gov/laws/generallaws/parti/titlexvii/chapter119/section51a [https://perma.cc/FDP5-29LF].

4. *See generally, e.g.*, C. Angelotta et al., *A moral or medical problem? The relationship between legal penalties and treatment practices for opioid use disorders in pregnant women*, 26 WOMEN'S HEALTH ISSUES 595 (2016).

5. We defer to critiques of the umbrella term "BIPOC," an acronym for "Black, Indigenous, and [other] people of color," that came into common use during and after the summer of 2020. *See, e.g.*, Meera Deo, *Why BIPOC Fails*, 107 VA. L. REV. ONLINE 115, 117 (2021), https://www.virginialawreview.org/articles/why-bipoc-fails/ [https://perma.cc/ED37-EXGL]. Deo points out that it is unhelpful at best to center Black and Indigenous experiences by using "BIPOC" in, for example, a discussion of COVID-19-related hate crimes against people of Chinese ancestry and people mistakenly believed to be of Chinese ancestry. *Id.* at 136. While the context of our work may

A state commission had recently convened to recommend reforms to the Massachusetts' mandated reporter law—not in response to any of these issues, but to the revelation that USA Gymnastics team doctor Larry Nassar had sexually abused hundreds of girls, including several Olympic athletes from Massachusetts.

What could Boston University School of Law do to make a difference for Dr. Saia's patients—and for the people (parents-to-be, parents, and children) who might be?

In February 2020, the three of us agreed to explore the possibility of a new medical-legal partnership ("MLP") that would support patients of Project RESPECT, a regional referral center and medical home for the treatment of substance use disorder in pregnancy.[6] Project RESPECT provides a comprehensive continuum of integrated perinatal care and addiction recovery treatment that spans from preconception counseling to long-term postpartum recovery. Established in 2006, Project RESPECT currently serves 150 birthing parent-baby dyads[7] each year—a volume that continues to increase. Project RESPECT's clients represent a highly vulnerable population with significant histories of trauma, medical and psychiatric comorbidities, intimate partner violence, housing and food insecurities, and conflict with the legal system. OUD is the most common

represent one of the "instances where both groups [Black people and Indigenous people] are at the center of the discussion and the data," and therefore that "BIPOC" would be appropriate, *id. at 127*, we attempt to follow Deo's recommendations to be precise about racial identity groups and to use language preferred by those identifying as members of those groups. In delineating racial and ethnic categorizations, use of the term *Black* throughout the piece refers to individuals identifying as "Black" or "African-American." Similarly, the use of "Indigenous" corresponds to individuals identifying as *American Indian* or *Alaskan Native*, while the use of "Hispanic" and "Latinx" correspond to those persons, of any race, who identify as Cuban, Mexican, Puerto Rican, South or Central American. "White" defines those with origins in any of the original peoples of Europe, the Middle East, or North Africa. The race and ethnicity standards employed by the U.S. Census Bureau were established by the Office of Management and Budget in 1997. *See* U.S. CENSUS BUREAU, *About the Topic of Race*, (Mar. 1, 2022), https://www.census.gov/topics/population/race/about.html. *See also* U.S. CENSUS BUREAU, *About the Hispanic Population and its Origin*, (Apr. 15, 2022), https://www.census.gov/topics/population/hispanic-origin/about.html.

6. "RESPECT" is an acronym for Recovery, Empowerment, Social services, Prenatal care, Education, Community, and Treatment.

7. Birthing parents may be of any gender identity. While most birthing parents identify as women and/or as mothers, research suggests that transgender men desire pregnancy at a rate similar to cisgender people. *See* Stephanie A. Gedzyk-Nieman & Jacquelyn McMillian-Bohler, *Inclusive Care for Birthing Trangender Men: A Review of the Literature*, 67 J. Midwifery & Women's Health 561, 562 (2022). More inclusive care practices and increasing research attention will allow for more nuanced understandings of the intersectional experiences of pregnant and parenting people with SUDs.

diagnosis among RESPECT's clients. Through a comprehensive program, patients have access to barrier-free and on-demand treatment, including acute, in-hospital stabilization and MOUD including methadone, suboxone, or naltrexone. Once stabilized on MOUD, clients participate in an intensive prenatal care and recovery curriculum through RESPECT's out-patient services. These services include relapse prevention visits with RESPECT's multidisciplinary team made up of nurse care specialists, licensed clinical social workers, peer recovery specialists, and obstetric and psychiatric providers. Individualized out-patient treatment plans are designed based on disease severity and recovery support needs.

At the time, the three of us envisioned launching a fully-integrated MLP incorporating 1) direct legal services, 2) mutual relationships and capacity-building between legal service and health care providers, and 3) advocacy for systemic change to support the health and wellbeing of the Project RESPECT patient population. Not quite two pandemic years in the making, the Boston University School of Law's Health Justice Practicum ("HJP") took its first steps, with six students and a systems change project focus, in January 2022.

Between the two of us lawyer-teachers, we had encountered "child welfare"[8] interventions as part of representing survivors of intimate partner violence,[9] worked on racial health inequities in a community-based coalition, and understood the opioid crisis from a health policy perspective. We each brought extensive experience in medical-legal partnership as well. But both of us had much to learn about addiction and its treatment, the family regulation system, and the particular confluence of social and structural determinants of health in the lives of low-income pregnant and parenting people with SUDs—most identifying as women. As we learned, we saw clearly that every aspect of this confluence was deeply racialized. If

8. The HJP, at least provisionally, has chosen "family regulation" to describe the state and local governmental agencies sometimes collectively called the "child welfare," "child protection," "family surveillance," or "family policing" authorities, depending on the source. *See, e.g.*, Dorothy Roberts, *The Regulation of Black Families*, REG. REV. (Apr. 20, 2022), https://www.theregreview.org/2022/04/20/roberts-regulation-of-black-families/ [https://perma.cc/U2GB-FUH4] (arguing for the abolition of the current system and calling for a "total paradigm shift in the state's relationship to families").

9. In the domestic violence context, these interventions can take the victim-blaming position that an abused parent endangers their child if the parent has any relationship with the abuser, regardless of circumstances that may make it economically impossible or even more dangerous for the abused parent to cut all ties.

we looked at systems change through the lens only of our medical partner's disproportionately white[10] patient population, the HJP would effectively be, in Llezlie Green's evocative phrase, "erasing race."[11] Galvanized by the renewed urgency of racial justice movements,[12] we thought this outcome would be unacceptable, particularly in an area like family law, which is so inextricably bound up with the history and present reality of race, especially anti-Black racism in the U.S. But, as this Essay will explain, the fact that our MLP medical partner's patients overwhelmingly identify as white actually presented an occasion for "un-erasing race" and for framing the HJP's work specifically as an antiracist health justice project.[13]

Part I will situate the HJP within the spectrum of MLP models and discuss increasing recognition of MLP as a public health tool, not just a direct legal services delivery model. It will also note important critiques of its racial equity record. Part II will describe the curriculum of the HJP's framing seminar component, which is informed and inspired by critical race methodologies, including the work of Angela Onwuachi-Willig, Dean of Boston University School of Law ("BU Law"), as well as by the work of noted historian and public intellectual Ibram X. Kendi, Director of the Center for Antiracist Research at Boston University, and recent writing by fellow clinicians Norrinda Hayat, Medha Makhlouf, and others. Part II will also outline the HJP's first semester focus on systems change advocacy and describe how centering race in supervision, rounds, and individual reflection supported students' critical and systemic appraisal of existing law and policy, options for response, and their (and our own) fieldwork. Finally, this Part will reflect on the law faculty members' positions as white women supervising this fieldwork. Part III will discuss why and how—in

10. At present, about 70% of RESPECT's patients identify as white, which does not reflect Boston Medical Center's overall patient demographics, where approximately 40% of patients are white.

11. Forum, Llezlie L. Green, *Erasing Race*, 73 SMU L. REV. 63 (2020), https://digitalcommons.wcl.american.edu/cgi/viewcontent.cgi?article=2181&context=facsch_lawrev/.

12. Both those sparked by the killings of George Floyd and Breonna Taylor, responding to police violence against Black people, and those documenting and responding to dramatic racial disparities in COVID-19 infections and deaths.

13. For the term "antiracist," *see, e.g.*, Ibram X. Kendi, HOW TO BE AN ANTIRACIST (2019) (as differentiated from assimilationist or segregationalist). For "health justice," *see, e.g.*, Emily Benfer et al., *Setting the Health Justice Agenda: Addressing Health Inequity & Injustice in the Post-Pandemic Clinic*, 28 CLINICAL L. REV. 45, 55 (2021) (concept "adds to the public health framework of health 'equity' by centering the critical role of law and policy in facilitating health disparities and in pursuing their elimination").

conjunction with ongoing Project RESPECT community engagement—the HJP's population legal needs assessment identifies and seeks to counteract the erasure of Black pregnant and parenting people with SUDs. The Conclusion will offer some provisional thoughts on continuing to improve the HJP. It will also discuss how centering racial health justice in an MLP addresses new American Bar Association Standard 303(b), which requires law schools to "provide substantial opportunities to students for . . . the development of a professional identity," as well as new Standard 303(c), which requires law schools to educate students about "bias, cross-cultural competency, and racism."[14]

I. MEDICAL-LEGAL PARTNERSHIPS AND PUBLIC HEALTH

Though MLPs take many forms, the model fundamentally seeks to bring lawyers and legal workers into health care settings serving low-income people to address patient problems that cannot be resolved with conventional health care services.[15] For instance, a child with acute asthma who lives in moldy rental housing can experience improved health when a lawyer helps the child's family hold the landlord to legal habitability standards. By definition then, MLPs address social determinants of health ("SDH" or "SDOH"): the conditions into which people are born, grow, work, live, and age, which are estimated to account for at least a third to one half of health outcomes.[16] A well-integrated MLP functioning in all three dimensions described in the introduction—direct individual representation, institutional capacity-building, and systems change advocacy—can

14. SECTION OF LEGAL EDUC. & ADMISSIONS TO THE BAR, AM. BAR ASS'N, REPORT TO THE HOUSE OF DELEGATES 4-6 (2022), https://www.americanbar.org/content/dam/aba/administrative/news/2022/02/midyear-hod-resolutions/300.pdf.

15. *See generally, e.g.*, Marsha Regenstein, Jennifer Trott & Alanna Williamson, *The State of the Medical-Legal Partnership Field*, NAT'L CTR. FOR MED.-LEGAL P'SHIP (Aug. 2017)), https://medical-legalpartnership.org/mlp-resources/2016-ncmlp-survey-report/.

16. Estimates of SDOH impact on health outcomes vary considerably, perhaps depending on the setting/s, population/s, and determinant/s considered. The World Health Organization, for example, cites "numerous studies [that] suggest that SDH account for between 30-55% of health outcomes." *Social Determinants of Health*, WORLD HEALTH ORGANIZATION (2022), https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1 [https://perma.cc/93GN-G87F] (last visited July 30, 2022). Other research finds that SDOH "drive as much as 80% of health outcomes." Manatt, Phelps & Phillips, LLP, *Medicaid's Role in Addressing Social Determinants of Health*, ROBERT WOOD JOHNSON FOUND. (Feb. 1, 2019), https://www.rwjf.org/en/library/research/2019/02/medicaid-s-role-in-addressing-social-determinants-of-health.html [https://perma.cc/4EPV-NKF7].

therefore create a direct line between affected individuals, populations, and systems that embody and reproduce structural inequities. Such a partnership can mobilize the combined clout and organization of multiple professions and constituencies to change laws, regulations, policies, and practices.

MLPs have most often launched by providing direct legal representation to individual patients identified by health care providers as having unmet legal needs.[17] To be responsive to the issue that prompted Project RESPECT to reach out to BU Law, as well as for practical reasons, the Health Justice Practicum launched from the opposite end of the MLP spectrum. In its first semester, the HJP launched three projects. The first focused on the movement to reform Massachusetts' mandated reporter statute. The second was a collaboration with BU Law's Legislative Policy & Drafting Clinic and the Legislative Analysis and Public Policy Association, a not-for-profit based in Washington, DC. This project focused on developing model state legislation aimed at reducing the number of unwarranted child removals from families with a parent in recovery from an SUD, and particularly on reducing racially inequitable treatment of these families and the resulting racialized health disparities.[18] The third project, described in more detail in this essay, is a population legal needs assessment.

Like all MLP systems change efforts, we see the projects as public health interventions as well as legal reforms.[19] The National Institute on Drug Abuse ("NIDA") estimates that more than 180 people die in the U.S. every day due to opioid overdoses,[20] and Massachusetts data shows that the most common cause of pregnancy-associated mortality is substance use disorder.[21] Opioid overdose-related deaths are increasing, including among

17. This proposition reflects Danielle Pelfrey Duryea's role as a primary source of information in her work with MLPs.

18. The HJP and the Legislative Policy & Drafting Clinic, directed by Professor Sean Kealy, are grateful for the support of the Legislative Analysis & Public Policy Association for the model state legislation project. LAPPA is a 501(c)(3) not-for-profit; for this project, the HJP and LPDC are subgrantees of funding originating in the federal Office of National Drug Control Policy.

19. MLP is increasingly recognized as a potentially powerful public health tool. *See, e.g.*, Dayna Bowen Matthew, *The Law as Healer: How Paying for Medical-Legal Partnerships Saves Lives & Money*, BROOKINGS (Jan. 30, 2017), https://www.brookings.edu/research/the-law-as-healer-how-paying-for-medical-legal-partnerships-saves-lives-and-money/ [https://perma.cc/VPW6-PRGZ].

20. *See Overdose Death Rates*, NAT'L INST. HEALTH: Trends & Stats. (Jan. 20, 2022), https://nida.nih.gov/research-topics/trends-statistics/overdose-death-rates (stating that overdose deaths involving any opioid totaled 68,630 in 2020).

21. *See generally* Mass. Gen. Hosp. Ctr. for Women's Mental Health, *Massachusetts Maternal Mortality Rates Rising: Opioid Abuse and Psychiatric Illness Play a Role*, MGH CTR. FOR WOMEN'S

Black, Indigenous, and Hispanic/Latino/Latina/Latinx populations.[22] Maternal morbidity related to substance use includes hepatitis C infection, HIV, bacterial endocarditis (infection in the heart valves), and prolonged length of hospital stays. Substance use in pregnancy is also linked to adverse outcomes in newborns, including intrauterine growth restriction and low birth weight, preterm birth, and respiratory and feeding problems.[23]

But becoming pregnant can be a powerful incentive to a person with a SUD to seek treatment, and can provide the patient and their health care team the opportunity to create an intensive treatment plan with a goal of long-term recovery. For pregnant persons with OUD, initiating MOUD is the standard of care.[24] Data shows that MOUD (methadone or buprenorphine) significantly reduces fatal overdose events, increases engagement in and duration of care, and improves maternal health and birth outcomes.[25] However, in Massachusetts, MOUD treatment during pregnancy identified via the electronic medical record generally triggers a report to the Department of Child and Family Services (DCFS) upon

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MENTAL HEALTH REPROD. PSYCHIATRY RES. & INFO. CTR., (Dec. 11, 2018), https://womensmentalhealth.org/posts/massachusetts-maternal-mortality-rates-rising-2018/.

22. *See* U.S. Ctrs. Disease Ctrl & Prev., Drug Overdose Death Rate Maps & Graphs (2022) (national rate of overdose deaths increased by 31% from 2019 to 2020); U.S. Ctrs. Disease Ctrl & Prev., Press Release, Overdose Death Rates Increased Significantly for Black, American Indian/Alasks Native People in 2020 (July 19, 2022); Mass. Dep't Pub. Health, Press Release, Massachusetts Rate of Opioid-Related Overdose Deaths Increased 8.8 Percent in 2021 Compared to 2020 (June 8, 2022), at https://www.mass.gov/news/massachusetts-rate-of-opioid-related-overdose-deaths-increased-88-percent-in-2021-compared-to-2020#:~:text=In%202021%2C%20the%20opioid%2Drelated,100%2C000%20in%20the%20prior%20year (overdose deaths among Black and Asian/Pacific Islander residents were down slightly year over year; among Hispanic/Latinx and Indigenous residents, deaths were up). On the use of "Hispanic," "Latinx," etc., *see* Sophie Yarin, *If Hispanics Hate the Term "Latinx," Why Is It Still Used?* BU TODAY (Oct. 7, 2022), https://www.bu.edu/articles/2022/why-is-latinx-still-used-if-hispanics-hate-the-term/ [https://perma.cc/6WH5-P6G6].

23. *See generally* T. Binder & B. Vavrinková, *Prospective randomized comparative study of the effect of buprenorphine, methadone and heroin on the course of pregnancy, birthweight of newborns, early postpartum adaptation and course of the neonatal abstinence syndrome (NAS) in women followed up in the outpatient department* 29 NEURO ENDOCRINOLOGY LETTERS 80 (2008) (discussing the effects of substance abuse on pregnant persons).

24. Jennifer J. Carroll et al.,.,*Linking People with Opioid Use Disorder to Medication Treatment: A Technical Package of Policy, Programs, and Practices*, NAT'L CTR. FOR INJURY PREV. & CTRL, U.S. CTRS. FOR DISEASE CTRL & PREV.,(Mar. 15, 2022), https://www.cdc.gov/drugoverdose/pdf/pubs/linkage-to-care_edited-pdf_508-3-15-2022.pdf, at 7.

25. *See generally* U.S. SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., *Clinical Guidance for Treating Pregnant & Parenting Women with Opioid Use Disorder and Their Infants*, (2018), https://store.samhsa.gov/sites/default/files/d7/priv/sma18-5054.pdf, at 29-30.

delivery.[26] Pregnant people, especially pregnant people of color, are aware of the legal implications of electronic medical record documentation, and the fear of such repercussions could deter pregnant persons from accepting this life-saving intervention. The unintentional harm generated by this legislation is not recognized outside of the obstetric exam room, however; our MLP provides a dynamic feedback loop between the medical system and legislation, between patient and policy. The moment a pregnant person declines MOUD for opioid use disorder in fear of being reported to DCFS, their disease sequelae worsens, and they move further from recovery. They retreat from prenatal care, which worsens maternal and fetal outcomes and can frequently prompt an emergency response from the child welfare system.[27] Undoubtedly, this sequence of events increases the financial burden on the health care system and state and federal government.

Notwithstanding its promise as a public health tool, MLP has underperformed as an intervention advancing racial health equity and racial health justice.[28] High among the reasons is what Medha Makhlouf calls a "'colorblind' conception of MLPs" that "assum[es] that anti-poverty advocacy is racial justice advocacy."[29] Until MLPs consciously and explicitly center race and racism, they risk providing mere "services for the poor" that respond to effects of racism as a social determinant of health rather than to the ultimate cause of racial health disparities, which is structural racism itself.[30]

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26. For a substance exposed newborn, the hospital social worker does not need consent from the birthing person to review medical records and report urine drug tests and medications to DCFS.

27. *See* Kelley Saia et al., *Caring for Pregnant Women with Opioid Use Disorder in the USA: Expanding and Improving Treatmen*t, CURRENT OBSTETRICS & GYNECOLOGY REPORTS (2016).

28. *See generally* Medha D. Makhlouf, *Towards Racial Justice: The Role of Medical-Legal Partnerships*, 50 J. L. MED. & ETHICS 117 (2022); Shek, *supra* note 1; Benfer, *supra* note 13.

29. Chronic underfunding of MLP work and incomplete integration of legal service providers with their health care partners may also be contributing factors in MLPs that do not take on systems change advocacy as part of their scope of activity. Makhlouf, *supra* note 28.

30. Shek, *supra* note 1, at 124. *See also, e.g.,* Ruqaiijah Yearby, *Structural Racism and Health Disparities: Reconfiguring the Social Determinants of Health Framework to Include the Root Cause*, 48 J. L. MED. & ETHICS 518, 518-20 (2020). While the value of individual legal services to people living in poverty must not be dismissed, the health justice framework elucidates the connections between structural determinants of health and individual legal needs. *See generally*, Benfer, *supra* note 13. As the National Center for Medical-Legal Partnership has long recognized, interventions at the systems level have the potential to improve health for many more people at once. *See* NAT'L CTR. MED.-LEG. P'SHIP, *The Response*, https://medical-legalpartnership.org/response/ (summarizing range of potential MLP activities).

II. CENTERING RACE AND RACISM IN THE HJP

Unlike, say, civil rights law, mandated reporter and other family regulation law does not generally acknowledge race or racism on its surface. To *colorblindly* teach law students in an MLP serving pregnant and parenting people with SUDs, however, would have been an enormous distortion.

Prenatal, perinatal, fetal, and infant health in the U.S. is rife with racial and ethnic inequities. Black and Hispanic/Latino/a/Latinx women[31] are more likely to deliver preterm compared to white women.[32] A higher proportion of Black women experience perinatal losses (such as miscarriage, ectopic pregnancy, stillbirth, and neonatal death) and infant death compared with other races.[33] Additionally, Black women experience high rates of pregnancy-related medical conditions and death, and are two to four times more likely to die during the peripartum period.[34] The reasons for these disparities are complex, but one driving force is compounding social and economic disadvantage that put low-income women of color and their newborns at risk for death and illness.

There are similar disparities in access to treatment for addiction. Black, non-Hispanic people are less likely to receive treatment within 30 days after an opioid-related overdose.[35] In Boston, the odds for follow-up treatment for Black residents is 58% less than for white residents.[36] Black patients are less likely to receive buprenorphine treatment prescriptions for OUD, despite buprenorphine treatment leading to better health outcomes.[37] While

31. Available data does not yet account for the population of birthing parents who do not identify as women.

32. *See, e.g.*, Latoya Hill et al., *Racial Disparities in Maternal & Infant Health: Current Status & Efforts to Address Them* KAISER FAMILY FOUNDATION (Nov. 1, 2022), https://www.kff.org/racial-equity-and-health-policy/issue-brief/racial-disparities-in-maternal-and-infant-health-current-status-and-efforts-to-address-them/#:~:text=Infants%20born%20to%20Black%20women,as%20high%20(Figure%205).

33. *Id.*

34. *Id.*

35. *See generally* Mara A.G. Hollander et al., *Racial Inequity in Medication Treatment for Opioid Use Disorder: Exploring Potential Facilitators and Barriers to Use*, 227 DRUG & ALCOHOL DEPENDENCE (2021).

36. CENTERS FOR DISEASE CONTROL & PREVENTION, OVERDOSE DEATH RATES INCREASED SIGNIFICANTLY FOR BLACK, AMERICAN INDIAN/ALASKA NATIVE PEOPLE IN 2020 (2022).

37. *See* Mary Peeler et al., *Racial & Ethnic Disparities in Maternal and Infant Outcomes Among Opioid-Exposed Mother-Infant Dyads in Massachusetts (2017-2019)*, 110 AM. J. PUB. HEALTH 1828 (2020).

opioid-related deaths are higher among white people, people of color are underrepresented in SUD treatment, so treatment demographics do not accurately reflect the demographics of people with SUD. Ultimately, pregnant Black women with SUD are the sub-population at highest risk for maternal mortality in Massachusetts.[38]

The family regulation system reflects troubling issues that compound these health inequities for parents as well as children. A decade of national data indicates that 53% of Black children in the U.S. were the subject of a child welfare authority investigation during their childhoods, versus 23% of white children.[39] Most investigations have found that race is a significant factor in reporting suspected child abuse or neglect to authorities.[40] Children in the foster system in the U.S. are disproportionately Black, Indigenous, and multiracial.[41] For example, in 2018, Black children comprised 13.71% of the U.S. population under eighteen, but 22.75% of children in foster care; meanwhile, white children comprised 50.5% of the U.S. child population, yet accounted for only 44.37% of children in the foster system.[42] Infants under one year old are separated from their families at higher rates than older children,[43] and family separation has documented detrimental effects for both children and parents.[44] A growing body of literature documents the

38. *Id.*

39. Hyunil Kim et al., *Lifetime Prevalence of Investigating Child Maltreatment Among US Children*, 107 AM. J. PUB. HEALTH 274, 277 (2017), https://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2016.303545 (based on 2003–2014 National Child Abuse and Neglect Data System (NCANDS) Child Files. The national repository for child abuse and neglect reports in all 50 states, the District of Columbia, and U.S. territories Cases that are "screened out"—i.e., reported to authorities but not investigated—are not evaluated by this study).

40. Robert B. Hill, *Synthesis of Research on Disproportionality in Child Welfare: An Update*, CASEY-CSSP ALLIANCE FOR RACIAL EQUITY IN THE CHILD WELFARE SYSTEM (Oct. 2006), (2006), https://assets.aecf.org/m/resourcedoc/aecf-CFS-SynthesisOfResearchOnDisproportionalityInChildWelfareAnUpdate-2006.pdf [https://perma.cc/5R2Y-MH26], at 17-18.

41. *Disproportionality and Race Equity in Child Welfare*, NAT'L CONF. OF STATE LEGISLATURES (Jan. 26, 2021), https://www.ncsl.org/research/human-services/disproportionality-and-race-equity-in-child-welfare.aspx [https://perma.cc/ZX7M-8TL9] (using data from the Annie E. Casey Foundation Kids Count Data Center)**.**

42. *Id.* Further, less than 1% of the U.S. child population in 2018 were identified as Indigenous, yet they made up 2.4% of children in foster care. Children identified as "Hispanic" and those identified as "Asian" were both underrepresented in foster care.

43. *See* Hill, *supra* note 40, at 23 (summarizing findings of FRED WULCZYN ET AL., BEYOND COMMON SENSE: CHILD WELFARE, CHILD WELL-BEING, AND THE EVIDENCE FOR POLICY REFORM (2005)).

44. *See, e.g.*, CHILD.'S RTS. LITIG. COMM., AM. BAR ASS'N SECTION OF LITIG., TRAUMA CAUSED BY SEPARATION OF CHILDREN FROM PARENTS (2020), https://www.americanbar.org/content/dam/aba/publications/litigation_committees/childrights/child-separation-memo/parent-child-

racially differential effects of maternal substance use on child welfare reporting, regardless of outcome.[45] In one study, despite similar rates of use between Black and white pregnant women, Black women were ten times more likely to be reported to child welfare authorities for substance use during pregnancy—even though state law mandated that all such instances be reported.[46]

With core principles of critical race theory and antiracism firmly in mind, we planned a seminar curriculum that looked to history and journalism centering anti-Black racism and misogynoir[47] in the family regulation, drug policy, health care, and related systems, and offered a health justice frame for the students' work.[48] We took as foundational principles, for example, that "racism is ordinary, not aberrational";[49] that race is a social construction rather than "objective, inherent, or fixed";[50] that differential racialization means that racial identities can signify differently over time depending on shifting social conditions; that individual social positions and experiences are produced through the intersection of multiple identity categories; and that the voices of racially minoritized people are integral to antiracist action.[51] So, from the first day of class and throughout the semester, seminar assignments focused on how racial and gender identities intersect with experiences of trauma, substance use, and pregnancy, and on the legal regimes and cultural narratives that structure this intersection, concentrating on the experiences of Black women. Together we read Dorothy Roberts on the family regulation system[52] and compared her account of that system with a conventional one that barely

separation-trauma-memo.pdf (summarizing literature on effects of family separation on children).

45. *See* Hill, *supra* note 40, at 17-19 (providing a summary of literature).

46. I. Chasnoff, H. Landress & M. Barrett, *The prevalence of illicit-drug or alcohol use during pregnancy and discrepancies in mandatory reporting in Pinellas County, Florida*, 332 New Eng. J. Med. 1202 (1990).

47. The term "misogynoir" was coined by feminist communications scholar Moya Bailey and writer-photographer Trudy in 2008 to characterize specific forms of anti-Black misogyny experienced by Black women. *See* Moya Bailey & Trudy, *On Misogynoir: Citation, Erasure & Plagiarism*, 18 FEMINIST MEDIA STUDIES 762, 762 (2018).

48. As we began to conceptualize the HJP course in detail, new publications helped us to clarify what was required of us. *See, e.g.*, Norrinda Brown Hayat, *Freedom Pedagogy: Toward Teaching Antiracist Clinics*, 28 CLINICAL L. REV. 149 (2021).

49. RICHARD DELGADO ET AL., CRITICAL RACE THEORY: AN INTRODUCTION 8 (3d ed. 2017).

50. *Id.* at 9.

51. *Id.* at 8-11 (summarizing core tenets of critical race theory).

52. *See generally* Dorothy E. Roberts, *Child Welfare & Civil Rights*, 2003 U. ILL. L. REV. 171 (2003).

mentioned race.[53] To learn about addiction and its treatment, we went to sources on culturally-responsive treatment for women with addiction. We read about putting trauma-informed lawyering to work in multiracial contexts and to specifically antiracist ends. We connected how pernicious racist stereotypes about Black mothering cross-pollinated with stigma associated with addiction. To learn about the opioid crisis, we read comparisons of the popular narrative around opioid addiction and the history of the *War on Drugs* that resulted in mass incarceration of Black men. We discussed Kendi's theory that racist policies produce racist beliefs, not the other way around.[54] The curricular goal was to support students in "consistently identify[ing] and describ[ing]"[55] the racialized roots and impacts of the laws, policies, and practices that converge in the lives of low-income pregnant and parenting people with SUDs.

In addition to the readings and discussion in our seminar component, supervision, project rounds, and individual reflection also took up the topic of how race and racism inflected each of the clinic projects and students' individual and collective work on them.

Our first cohort of students—racially diverse and all six identifying as women—responded positively. They shared their knowledge and life experiences in both the seminar's framing discussions and fieldwork supervision discussions.[56] As young adults in their mid-20s, they also brought to the classroom and the fieldwork a *mostly* shared vocabulary for discussing race and systemic racism shaped by increasing academic and popular attention in the 2010s, including the mid-decade emergence of the Black Lives Matter movement, the spread of the concept of intersectionality, and the urgent public protests of police violence against Black communities beginning in May 2020. From the outset and throughout the classroom component of the course, students thought about "pregnant/parenting person with a SUD" not as a unitary identity. Rather, students considered the convergence of multiple social and structural

53. *See generally* John E.B. Myers, *A Short History of Child Welfare in America*, 42 FAMILY L. QTLY 449 (2008).

54. *See, e.g.*, IBRAM X. KENDI, STAMPED FROM THE BEGINNING: THE DEFINITIVE HISTORY OF RACIST IDEAS IN AMERICA 9 (2016).

55. "The only way to undo racism is to consistently identify and describe it—and then dismantle it." KENDI, *supra* note 13, at 12.

56. For privacy reasons, we did not inquire into identities or experiences that students did not voluntarily disclose.

determinants that produce each person's identities and health outcomes and which demand to be evaluated as just or unjust.

By centering the intersectional positions of people who are significantly *not* present among past and current RESPECT patients, HJP students developed more comprehensive legislative and policy proposals, identified a more inclusive universe of stakeholders, and drew more expansive connections among forms of racism, misogyny, and stigma. For instance, the student-advocate team working on model state legislation proposed to require mandated reporters with state licensure and family regulation agency staff to engage in education to combat implicit bias. Without a foundation in the role of racism in the family regulation system, it seems unlikely that this requirement would have become a crucial piece of their reform proposal. As another example, the student-advocate team developing statewide stakeholder and power maps[57] for upcoming Massachusetts mandated reporter law reform prioritized a wide range of Black-led community organizations and Black elected officials. These include those not focused on health or families, as important stakeholders, which students in a *colorblind* MLP might have overlooked.

We rejoiced in the diverse group of JD and JD/MPH joint-degree students who had chosen to launch the HJP with us, while recognizing the limitations of two white, cisgender women lawyers supervising their work. Taking to heart Kendi's maxim that "being an antiracist requires persistent self-awareness, constant self-criticism, and regular self-examination,"[58] we are committed to continuously expanding our knowledge about racism and its effects, enhancing our self-awareness, opening ourselves to critique, and examining our organizational and pedagogical priorities and choices for racial and other biases. We are also committed to stepping back while we are supervising HJP work and stepping aside for leadership. In one sense, stepping back is integral in clinical pedagogy—that is, as faculty

57. *See, e.g.*, FRANCISCO VALDES ET AL., CRITICAL JUSTICE 944-53 (2021) (describing techniques for identifying issue stakeholders, their relationships to each other and ultimate decisionmakers, and ultimate decisionmakers' priorities and motivations).

58. KENDI, *supra* note 13, at 9. A similar point is expressed by many racial justice organizers and writers, especially those addressing white would-be allies—or co-conspirators—in the movement for racial justice. *See also, e.g.*, Sherry K. Watt, *Self-Examination on the Road to Being Anti-Racist*, IOWA MAGAZINE (Sept. 11, 2020); City of Seattle Race & Social Justice Initiative, *Building Capacity for Transformational Anti-Racist Organizing Within Government* (Jan. 2022), https://www.seattle.gov/documents/Departments/RSJI/Shape-of-Trust/Report/Shape-of-Trust-Report-January-2022.pdf.

supervisors, stepping back so that law students can take the lead lawyering roles wherever and whenever possible. To step back in this context, however, also meant to defer to our students' lived experiences, including their points of connection and disconnection with low-income, pregnant, and parenting Black people with SUDs. Stepping aside means both deferring to people with lived experiences and being prepared to step aside for future HJP leadership whose lived experiences as Black people and/or pregnant or parenting people with SUDs will connect them more closely with the most vulnerable people whom this MLP is intended to serve. For now, the two of us white women are here, with some relevant experience and some capacity to help launch this project. As the AALS Section on Clinical Legal Education Policy Committee and the Clinical Legal Education Association (CLEA) Committee for Faculty Equity and Inclusion have stated, "[I]t is well known that there is a crisis of diversity among clinical faculties."[59] Explanations, however, are not excuses,[60] and we lawyers hope to be replaced.

III. WHY POPULATION LEGAL NEEDS ASSESSMENT MATTERS TO MLP AS A TOOL FOR PUBLIC HEALTH & RACIAL HEALTH JUSTICE

As discussed above, from the beginning, our vision has been both to provide individual legal services to Project RESPECT patients that will help improve their health outcomes, and to work on systemic change to support pregnant and parenting people with SUDs in Massachusetts and beyond. To ground the MLP, the third project in the HJP's first semester was to initiate a legal needs assessment to help determine what legal services, policy changes, and legislative goals would best contribute to creating better health outcomes not only for Project RESPECT patients, but also for those low-income Boston-area pregnant and parenting people with SUDs who are not accessing pre-natal, perinatal, addiction treatment, and other health care at all[61]—particularly prospective patients who identify as Black.

59. Deborah Archer et al., *Clinicians Reflect on COVID-19: Lessons Learned and Looking Beyond*, 28 CLINICAL L. REV. 15, 36 (2021) (citing Comm. for Fac. Equity & Inclusion, Clinical Leg. Educ. Ass'n, *The Diversity Imperative Revisited: Racial and Gender Inclusion in Clinical Law Faculty*, 26 CLINICAL L. REV. 127 (2019)).

60. *Id.*

61. Or through the HOPE Clinic, a similar specialty practice based at Massachusetts General

In many MLPs, legal needs are assessed individually in the health context, typically using in-appointment oral screening by a health care provider trained to spot legal issues and/or a screening tool that asks patients for a snapshot of their current problems, if any, in specific areas where legal support may be helpful.[62] These questions often seek information in the following areas: Income and Insurance, Housing and Utilities, Education and Employment, Legal Status (including immigration, post-incarceration, and/or military status), and Personal and Family Stability (which may include family law, intimate partner and neighborhood violence, and advance planning for health care and financial decision-making).[63] Research indicates that most low-income patients have an average of two unmet legal needs.[64]

Without a valid and thorough legal needs assessment of the population for whom the health care and legal services are intended, an MLP must rely on limited and potentially non-representative observations of patient-client experiences, anecdotal and possibly biased reports from health care partners, or speculation about how legal needs are acting as (and interacting with) social determinants of health in people's lived experience. This lack of knowledge risks systems-level interventions that replicate rather than ameliorate existing inequities, particularly in a situation where the patient population does not accurately represent the affected population. So, as in the other Practicum projects, the question is: what does an antiracist population legal needs assessment of pregnant and parenting people with SUDs look like?

- First, it should address the systemic underrepresentation of low-income Black pregnant and parenting people with SUDs in RESPECT's patient

Hospital. https://www.massgeneral.org/obgyn/treatments-and-services/hope-clinic Last visited 11/12/2022.

62. *See, e.g.*, Jennifer Trott & Marsha Regenstein, National Center for Medical-Legal Partnership, Screening for Health-Harming Legal Needs (2016), at https://medical-legalpartnership.org/mlp-resources/screening-brief/.

63. *Id. See also How Legal Services Help the Health Care System Address Social Needs*, NAT'L CENTER FOR MED.-LEGAL P'SHIP: THE RESPONSE (2022), https://medical-legalpartnership.org/response/i-help/.

64. Elizabeth Tobin Tyler, *Medical-Legal Partnership in Primary Care: Moving Upstream in the Clinic*, 13 AM. J. LIFESTYLE MED., 282, 283 (2017), doi.org/10.1177/1559827617698417.

population (and, to varying extents, other potential patients who are people of color).

- Second, it should help to explain the reasons for this underrepresentation.
- Third, it should prioritize the voices and preferences of people with lived experience as low-income pregnant and parenting people with SUDs in Massachusetts and allow us to see whether these priorities and preferences differ along racial and/or other lines of identity or experience.
- Fourth, it should assess whether and why there might be gaps between service providers' understanding of the impacts of laws and policies on their patients/clients and the perspectives of the patients/client themselves.

The HJP team, including two JD/MPH students, conceptualized a mixed-method legal needs assessment with past and present patients of Project RESPECT and with community members who have been or are eligible, but have not been and are not presently. The team did not find an existing legal needs assessment methodology for identifying specifically the priority legal needs of pregnant and parenting people with SUDs, but we looked to other MLPs and organizations that conduct legal needs assessments to learn more. The outcomes include:

1. Understanding the self-identified needs and priorities of low-income Massachusetts pregnant and parenting people in recovery from SUDs who select in for Project RESPECT health care as well as those who either opt out or are unaware of it;
2. Providing additional information to support Project RESPECT in its ongoing efforts to provide care to

more people, especially more Black people and other people of color;[65]

3. Enhancing provider understanding of law and policy as structural/social determinants of health;
4. Understanding better how race, ethnicity, sexual orientation, gender identity, and disability differentially intersect with legal and policy determinants of health; and
5. Involving people with lived experience in crafting systemic responses that are attentive to, and meaningfully respond to, intersectional differences.

The assessment plan incorporates ethical practices for research with marginalized populations, including compensation for participants' time. We are seeking Institutional Review Board (IRB) approval so that we are able to share our methodology and results with others outside of the MLP.

The current plan includes three components: 1) an anonymous survey of current Project RESPECT patients, 2) focus groups including both patients and nonpatients, and 3) a survey of RESPECT and community recovery housing staff. The anonymous questionnaire is designed to discover the priority legal needs of existing patients who are pregnant or parenting with SUDs. The anonymity of people completing the questionnaires means the results cannot be used to provide individual follow-up legal services. However, with the aggregated information, we

65. Since 2017, the Project RESPECT Pregnant Women of Color with Substance Use Disorder Initiative has aimed to reform RESPECT's model of care to better address the needs of women of color and to effectively engage pregnant people of color with SUDs, especially from Black communities in the Boston area. Recognizing racial health disparities discussed above, such as lower rates of engagement and retention in substance use care and lower rates of initiation in prenatal care in the first trimester, as well as a host of barriers including increased stigma, experiences of institutional racism and individual bias in the health care system, fear of legal consequences, and fear of loss of custody, the Initiative's goal is to increase the number of women of color receiving and engaging with prenatal substance use disorder care. The Initiative has built on Project RESPECT's existing program for Latina/Hispanic women with SUDs and their children at Entre Familia, a residential treatment facility in Mattapan, Massachusetts. In this program, a bilingual, Latina Project RESPECT social worker and a Project RESPECT clinical child life specialist facilitate weekly support groups on-site at Entre Familia, providing culturally responsive care and a linkage to the RESPECT clinic.

hope to identify the existing priority legal needs of current Project RESPECT patients.

In addition to this survey, and in collaboration with community-based organizations and advocates, we will hold focus groups for people with SUDs who have given birth and are continuing to receive services while living in transitional group housing. These focus groups will include both Project RESPECT patients and people who are not patients of Project RESPECT. From these groups, we hope to gather more in-depth information about legal problems and barriers that participants have experienced both across their lifespans and specifically during pregnancy and in the early months of their children's lives. The transitional housing is specifically for women who need housing, recovery, and other services after delivery. These facilities serve a more racially diverse group than the current Project Respect patients. The two transitional housing centers prioritize outreach and support for Latina/Hispanic women and Black women, respectively.

The survey and focus groups with existing Project RESPECT patients and with other pregnant and perinatal individuals in transitional housing will also seek to identify other government or provider policies or practices that negatively affect pregnant and parenting people with SUDs. The intent is to aggregate this information on policy problems to see what patterns emerge.

Finally, the legal needs assessment includes a questionnaire for all staff working for Project RESPECT, as well as staff of the transitional housing centers, to find out what health-related legal needs they identify for their patients and clients. The questionnaire also asks them to identify any policies that impose barriers to pregnant and parenting people with SUDs.

Across all components of the legal needs assessment, it is necessary to understand barriers to health care as well as to legal services. We also plan to identify and compare the legal needs and health care access priorities of different racial and ethnic groups. In doing this, we hope to learn how to better develop antiracist approaches to assessing and serving individual legal needs, as well as to legislative, policy, and other systems of advocacy.

CONCLUSION

The preparation for, and first semester of, the HJP was, obviously, just a start. It was only a tiny beginning of a process of naming and acting to

dismantle structural racism embodied in laws and policies affecting low-income, pregnant, and parenting people with SUDs. There is much room for improvement in upcoming semesters both in the classroom and in the fieldwork. Yet even the first semester seems a promising example of how academic MLPs[66] that undertake to be antiracist by design can 1) significantly change the terms of the conversation about social determinants of health and 2) help to fulfill two new curricular goals that are now required of all law schools by the American Bar Association.[67] Such MLPs can offer myriad opportunities both to develop law students' professional identities, and to educate on bias, culturally responsive lawyering,[68] and racism by responding to and reflecting broadly on the social determinants of health and on structural racism as the root cause of racial health inequities, specifically.

Most law school clinical and externship programs recognize professional identity formation as an important outcome of experiential learning, whether specified as a formal learning goal or not.[69] MLPs have an advantage in teaching professional identity because the norms, obligations, and values of at least two professions are always in play, creating opportunities to compare and contrast. Several academic MLPs have also regularly included one or more medical or social work students in a rotation through the MLP to enhance the inherently interprofessional experience of participating law students and health sciences students alike.[70]

66. "Academic MLPs" are those that include a law school as a legal partner in an MLP. Vicki W. Girard, et al., *The Academic Medical-Legal Partnership: Training the Next Generation of Health & Legal Professionals to Work Together to Advance Health Justice*, GEORGETOWN UNIV. HEALTH JUST. ALL. & NAT'L CTR. FOR MED-LEGAL P'SHIP, 5 (2022), https://medical-legalpartnership.org/mlp-resources/academic-mlp-report/.

67. SECTION OF LEGAL EDUC. & ADMISSIONS TO THE BAR, AM. BAR ASS'N, *supra* note 14, at 4-6. New Standard 303(b)(3) requires accredited law schools to provide "substantial opportunities . . . for the development of a professional identity." *Id.* at 4. New Standard 303(c) requires law schools to educate every student about "bias, cross-cultural competency, and racism" at least twice: "at the start of the program of legal education" and "at least once again before graduation." *Id.* at 4-5. New Interpretations 303-5, 303-6, 303-7, and 303-8 provide additional guidance on these two requirements. *Id.* at 5-6. Law schools must develop a plan by the Fall of 2022 for how to implement these two new requirements. *See* Neil Hamilton & Louis Bilonis, *Revised ABA Standards 303(b) and (c) and the Formation of a Lawyer's Professional Identity, Part 1: Understanding the New Requirements*, NALP BULLETIN (May 2022), https://www.nalp.org/revised-aba-standards-part-1.

68. *Id.*

69. Some schools, such as Fordham and Santa Clara, have been ahead of the ABA in developing professional identity curricula for all students. *See id.*

70. Interprofessional education (IPE) in the health professions is garnering attention in legal

As the ABA has now made clear, however, acculturating law students into "what it means to be a lawyer and the special obligations lawyers have to their clients and society" specifically includes:

> the importance of cross-cultural competency to professionally responsible representation and the obligation of lawyers to promote a justice system that provides equal access and eliminates bias, discrimination, and racism in the law.[71]

An MLP, particularly one with a strong systems change component that centers the experiences of racially minoritized people, can provide an opportunity for students gain deep insight into the nature of "bias, discrimination, and racism in the law." That is, bias, discrimination, and racism in the law are structural and intersectional, not incidental and individualized. This opportunity is present regardless of the substantive legal issue and, as efforts to "un-erase race" in our partnership suggest, whatever the MLP medical partner's patient population demographics may be.

An MLP that centers racism and minoritized people likewise presents rich opportunities for students to learn the "skill"[72] of culturally responsive lawyering in direct client service as well as in systems change work. No longer a "special topic" in class or occasional presence in case discussions/supervision meetings, understanding and discussing race and racist dynamics can be normalized as an essential part of lawyering in

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circles as a model for implementing Standard 303(b)(3): "Educators in medicine and nursing and top health care organizations in the world… have been working for years to learn how effectively to acculturate new entrants into deep care for the patient in teams." Hamilton & Bilonis, *supra* note 67 (citing Eric Holmboe & Robert Englander, *What Can the Legal Profession Learn from the Medical Profession about the Next Steps*, 14 U. ST. THOMAS L.J. 345, 345-56 (2018)). Some health professions' IPE programs have even brought lawyers and law students into regular dialogue with health professions students. During co-author Pelfrey Duryea's tenure on the Interprofessional Education Leadership Team at the University at Buffalo, for example, selected law students participated in Interprofessional Forums, which annually engaged hundreds of students from the health and "health-adjacent" disciplines in small-group peer learning discussions around a hypothetical patient case. *Cf. Interprofessional Forums*, UNIV. AT BUFFALO: OFF. OF INTERPROFESSIONAL EDUC. (2022) https://www.buffalo.edu/interprofessional-education/education/ipe-initiatives/IPForums.html (last visited July 30, 2022).

71. SECTION OF LEGAL EDUC. & ADMISSIONS TO THE BAR, AM. BAR ASS'N, *supra* note 14 , at 5 (Interpretations 303-5 and 303-6).

72. *Id.* at 5 (Interpretation 303-7).

service of clients at the intersection of racial and other identities—no longer a subject to be avoided in those settings.[73] In systems change work, an MLP that centers race and racism can introduce students to multiple forms of lawyering for racial justice, including community lawyering and movement lawyering,[74] in addition to individual client-centered representation that recognizes clients as the experts in their own lives. The latter includes " . . . their own lived experiences as Black people in America, [which are] literally central to understanding them and their legal cases and what will make them whole."[75]

Notwithstanding the title of this journal issue, we know our efforts are not truly "cutting edge."[76] The HJP is far from accomplishing even what Norrinda Brown Hayat has called the four "partial, preliminary, and contingent" steps toward building an antiracist clinical legal pedagogy:

> (1) centering Blackness; (2) mapping critical race theory onto clinical pedagogy; (3) citing Black women; and (4) aligning with Black folx[77] organizing for the Afrofuture where Black Lives Matter is not an aspirational proposition.[78]

The point of this Essay is simply to call back to those who have called out—in print as well as in countless conversations—for clinical legal education generally and MLPs in particular to rise to the antiracist challenge.

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73. *See* Hayat, *supra* note 48, at 156 (citing Sue Bryant and Jean Koh Peters' description of many clinic teachers' reticence about discussing race and wondering "how it is that our colleagues can represent Black and Brown people while also finding discussions about race so difficult.").

74. *See generally, e.g.*, GERALD P. LÓPEZ, REBELLIOUS LAWYERING: ONE CHICANO'S VIEW OF PROGRESSIVE LAW PRACTICE (1992); Alina Ball, *Transactional Community Lawyering*, 94 TEMP. L. REV. 397 (2022); Scott Cummings, *Movement Lawyering*, 2017 U. ILL. L. REV. 1645 ("an alternative model of public interest advocacy focused on building the power of nonelite constituencies through integrated legal and political strategies").

75. *See* Hayat, *supra* note 48, at 157.

76. *See*, *e.g.*, Hayat, *supra* note 48, at 168 (naming Michelle S. Jacobs, Gerry López, and Mari Matsuda among predecessors in the call to decolonize legal education).

77. *Folx* is a way of writing "folks," emphasizing the intention for the word to include all groups of people. *See* CAMBRIDGE DICTIONARY, https://dictionary.cambridge.org/us/dictionary/english/folx (last visited Nov. 18, 2022).

78. Hayat, *supra* note 48, at 155.