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Advancing Racial Justice through Civil and Criminal Academic Medical-Legal Partnerships

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ADVANCING RACIAL JUSTICE THROUGH CIVIL AND CRIMINAL ACADEMIC MEDICAL-LEGAL PARTNERSHIPS

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The medical-legal partnership (MLP) model, which brings attorneys and healthcare partners together to remove legal barriers to health, is a growing approach to addressing unmet civil legal needs. But MLPs are less prevalent in criminal defense settings, where they also have the potential to advance both health and legal justice. In fact, grave racial health inequities are deeply intertwined with both civil and criminal injustice. In both spheres, health justice is racial justice. Building on the experiences of the authors in their respective civil and criminal law school clinics at Georgetown University in Washington, D.C., this Article argues that academic medical-legal partnerships provide a unique vehicle for advancing racial justice by training future leaders in law and healthcare to understand, address, and dismantle intertwined health inequities and injustice across both civil and criminal legal systems.

I. INTRODUCTION - HEALTH JUSTICE AS RACIAL JUSTICE

In Washington, D.C., life expectancy in the city's predominantly white Ward 3 is 87 years.[1] Less than fifteen miles south and east, in Ward 8, which is majority Black, life expectancy is only 72 years, a full fifteen years shorter.[2] Other racial health disparities abound in D.C., with higher rates of asthma, cancer, maternal mortality, and other health conditions among Black Washingtonians.[3]

The disparities experienced by Washingtonians behind bars are compounded by additional environmental and structural threats to their health. For every year in prison, life expectancy decreases by two

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[1] CHRISTOPHER J. KING & PATRICIA CLOONAN, GEO. UNIV., HEALTH DISPARITIES IN THE BLACK COMMUNITY: AN IMPERATIVE FOR RACIAL EQUITY IN THE DISTRICT OF COLUMBIA 1 (2020).

[2] *Id.*

[3] *Id.*

years.[4] With Black people about five times more likely to be sentenced to prison time than their white counterparts,[5] there can be no justice without health. Health justice *is* racial justice.[6]

Health inequities, like legal ones, are deeply connected to social, structural, economic and political determinants of health. Research shows that as much as 80% of health is not driven by biology or medical care, but by the "social determinants of health," which are the conditions in which people live, work, learn, eat, and age.[7] These determinants of health are not just social, they are structural and political,[8] shaped by laws and policies deeply rooted in structural racism.[9] Racism itself harms health,[10] as do destructive conditions such as unsafe housing and incarceration.[11]

As a movement and scholarly framework, health justice requires the leveraging of law and policy to dismantle subordination as a root cause of health inequities.[12] Building on a vision of health equity in which all people have a fair and equal opportunity to achieve health, the term "justice" centers the importance of law in facilitating such equity. For people to achieve health and well-being, law must be used to ensure access to safe and affordable housing, healthy neighborhoods free of environmental hazards, housing and food security, and

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[4] Christopher King, Bryan O. Buckley, Riya Maheshwari & Derek Griffith, *Race, Place, and Structural Racism: A Review of Health and History in Washington D.C.*, 41 HEALTH AFFS. 273, 274 (2022).

[5] Leah Wang, *Punishment Beyond Prisons: Incarceration and Supervision by State*, PRISON POL'Y INITIATIVE (May 2023), https://www.prisonpolicy.org/reports/correctionalcontrol2023.html.

[6] Sheila Foster, Yael Cannon & Gregg Bloche, *Health Justice Is Racial Justice: A Legal Action Agenda for Health Disparities*, HEALTH AFFS. BLOG (July 2, 2020), https://www.healthaffairs.org/content/forefront/health-justice-racial-justice-legal-action-agenda-health-disparities.

[7] *Social Determinants of Health*, WORLD HEALTH ORG., https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1 (last visited May 25, 2023).

[8] DANIEL E. DAWES, THE POLITICAL DETERMINANTS OF HEALTH 7 (2020).

[9] 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 (2020).

[10] *Id.* at 518-19.

[11] Katherine Beckett & Allison Goldberg, *The Effects of Imprisonment in a Time of Mass Incarceration*, 51 CRIME & JUST. 349, 354-358 (2022); Thalia González & Emma Kaeser, *Race, Public Health, and the Epidemic of Incarceration*, 13 NEB. L. REV. BULL. 1, 2-4 (2022); Frank Griffin, *Administering Housing Law as Health Care: Attorneys as Healthcare Providers*, 71 S.C. L. REV. 349, 351, 355-356 (2019); Dayna Bowen Matthew, *Health and Housing: Altruistic Medicalization of America's Affordability Crisis*, 81 LAW & CONTEMP. PROBS. 161, 166-167 (2018); Emily A. Benfer & Allyson E. Gold, *There's No Place like Home: Reshaping Community Interventions and Policies to Eliminate Environmental Hazards and Improve Population Health for Low-Income and Minority Communities*, 11 HARV. L & POL'Y REV. ONLINE S1, S3 (2017).

[12] Lindsay F. Wiley, Ruqaiijah Yearby, Brietta R. Clark & Seema Mohapatra, *Introduction: What is Health Justice?*, 50 J.L. MED. & ETHICS 636, 636 (2022).

freedom from police violence, surveillance, and incarceration. Ultimately, health justice should engage the law and lawyers, as well as their interdisciplinary partners, in building the power of individuals and communities affected by health inequities "to create and sustain conditions that support health and justice."[13]

Medical-legal partnerships (MLPs) advance health justice by integrating lawyers onto healthcare teams to address legal needs that harm health and to advance policy change to promote health equity.[14] Most MLPs, including academic MLPs situated in universities, focus on civil justice issues that impact health, such as income, housing, utilities, education, employment, immigration, and family law.[15] But criminal injustice also contributes to health injustice. The MLP model, and the academic MLP in particular, can be used to advance racial and health justice by addressing the many legal needs and harmful policies that impact the health and well-being of people in the criminal legal system. Academic MLPs are uniquely positioned to advance racial justice by educating the next generation of lawyers and health professionals to understand and address the connections between structural racism, health, criminalization, and incarceration. Health justice crosses civil and criminal legal spheres, and academic MLPs can and should work towards health justice on both fronts.

Building on the experiences of the authors in their respective law school clinics at Georgetown University in Washington, D.C. and the research supporting the critical connections between racial inequities in both legal systems and health, this Article argues that academic medical-legal partnerships (A-MLPs) provide an important vehicle for training future attorneys, physicians, and other health professionals to advance health and racial justice not only through civil legal advocacy, but also through criminal legal advocacy. The Article offers specific approaches that A-MLPs should adopt in order to meaningfully promote racial justice in both the civil and criminal spheres.

A. Civil Injustice and Racial Health Inequities

Many areas of civil injustice lead to racial health inequities. Housing injustice provides a powerful example. Historically, redlining and restrictive covenants kept Black people and other people of color out of many neighborhoods and segregated them into areas with environ-

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[13] *Id.*

[14] Yael Zakai Cannon, *Medical-Legal Partnership as a Model for Access to Justice*, 75 STAN. L. REV. ONLINE 73, 74 (2023).

[15] Kate Marple, *Chart: How Legal Services Help the Health Care System Address Social Needs*, NAT'L CTR. FOR MED.-LEGAL. P'SHIP (Jan. 21, 2015), https://medical-legalpartnership.org/mlp-resources/messaging-chart/.

mental hazards and substandard housing conditions.[16] Housing discrimination, zoning ordinances and policies that promote gentrification continue to further these inequities in housing and neighborhood conditions.[17] Evictions and homelessness also disproportionately impact people of color.[18]

These housing injustices result in health injustices.[19] For example, mold, rodents, and roaches in a home exacerbate asthma and other respiratory conditions.[20] Lead in peeling paint and water can lead to brain damage and developmental delays for young children.[21] Evictions harm the health and mental health of children and adults.[22] Even the threat of eviction is a powerful stressor that impacts health and well-being.[23] Homelessness is tied to lower life expectancy and a number of health and mental health conditions, and can lead to traumatic experiences for children that are linked to long-term health harms.[24]

In Washington, D.C., racial inequities in housing that impact health abound. Black residents are overrepresented in the population of unhoused Washingtonians, making up 86.4 percent of this group, while representing only 46.6 percent of the District's population.[25] The rate of both eviction filings and executed evictions is substantially higher in Wards 7 and 8, which are wards with the largest share of Black residents and the highest poverty rates in the city.[26] In contrast, the wards with the lowest filing rate – Wards 2 and 3 – had among the lowest poverty rates and the smallest share of Black residents in the

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16 Foster et al., *supra* note 6.

17 *See id.*; BRUCE MITCHELL & JUAN FRANCO, NCRC, HOLC "REDLINING" MAPS: THE PERSISTENT STRUCTURE OF SEGREGATION AND ECONOMIC INEQUALITY (2018).

18 Foster et al., *supra* note 6.

19 Ericka Petersen, *Building a House for Gideon: The Right to Counsel in Evictions*, 16 STAN. J. C. R. & C. L. 63, 68–69 (2020); Yael Cannon, *Injustice is an Underlying Condition*, 6 U. PA. J.L. & PUB. AFFS. 201, 240–41 (2020).

20 Emily A. Benfer & Lindsay F. Wiley, *Health Justice Strategies to Combat COVID-19: Protecting Vulnerable Communities During A Pandemic*, HEALTH AFFS. BLOG (Mar. 19, 2020), https://www.healthaffairs.org/do/10.1377/hblog20200319.757883/full/ ("Low-income people are more likely to live in homes with poor air quality, mold, asbestos, lead, pest-infections, and inadequate space to separate the sick from the well. . . . which have all been linked to poorer health outcomes."); Cannon, *supra* note 19, at 250.

21 Emily A. Benfer, *Health Justice: A Framework (and Call to Action) for the Elimination of Health Inequity and Social Injustice*, 65 AM. U. L. REV. 275, 294–95 (2015); Cannon, *supra* note 19, at 245.

22 Petersen, *supra* note 19, at 69; Cannon, *supra* note 19, at 242.

23 Cannon, *supra* note 19 (2020), at 241–42.

24 Allyson E. Gold, *No Home for Justice: How Eviction Perpetuates Health Inequity among Low-Income and Minority Tenants*, 24 GEO. J. ON POVERTY L. & POL'Y 59, 61 (2016); Cannon, *supra* note 19 at 240–41.

25 Kate Akalonu, *Homelessness & Racial Inequity*, EVERYONE HOME DC (June 11, 2020), https://everyonehomedc.org/homelessness-racial-inequity/.

26 EVA ROSEN & BRIAN MCCABE, GEO. UNIV., EVICTION IN WASHINGTON, DC: RACIAL AND GEOGRAPHIC DISPARITIES IN HOUSING INSTABILITY 14 (2020).

city.[27]

The city also has significant disparities in home ownership. Although higher education is typically tied to higher incomes which should make homeownership more attainable, in 2016, 80 percent of white D.C. residents with a high school diploma or less were homeowners, while less than 45 percent of all Black D.C. residents, regardless of their educational attainment, were homeowners.[28] Homeownership is associated with fewer health conditions and improved psychological health; the connection between homeownership and health outcomes for members of racial minority groups, however, may be mitigated by the ongoing effects of structural racism and racial biases.[29]

Housing inequality and the legacy of redlining also present obstacles to access to healthcare for minoritized communities and people with low-income. Over the past two decades in Washington D.C., several hospitals that historically served communities of color have shut down essential healthcare services or closed down altogether.[30] For example, in 2001, District of Columbia General Hospital, which was known for its culturally nuanced care and medical education, closed its inpatient services and trauma wards.[31] United Medical Center (UMC), the only hospital in the predominantly Black wards east of the Anacostia River, recently ended many of its services, including a nursing facility and obstetrics ward, with plans to close the hospital by the end of 2023.[32] The closing of these hospitals serving majority Black communities in neighborhoods that are functionally medical deserts created even more obstacles for families with low income to access adequate primary care, emergency services, and prenatal care,[33] and exacerbated health inequities in Washington, D.C., such as

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[27] *Id*.

[28] KILOLO KIJAKAZI, RACHEL MARIE BROOKS ATKINS, MARK PAUL, ANNE PRICE, DARRICK HAMILTON & WILLIAM A. DARITY, JR., URB. INST., THE COLOR OF WEALTH IN THE NATION'S CAPITAL 7 (2016).

[29] *See* Selena E. Ortiz & Frederick J. Zimmerman, *Race/Ethnicity and the Relationship Between Homeownership and Health*, 103 AM. J. PUB. HEALTH e122, e127 (2013).

[30] *See* King et al., *supra* note 4 (discussing the influence of structural racism on health outcomes).

[31] *See id.* at 277 (explaining that D.C. General Hospital was known for its culturally nuanced care in providing inpatient and trauma for over 200 years in Washington D.C. before closing down. The hospital was a "medical home for the disenfranchised, low income, and uninsured").

[32] *See id.* at 278 (explaining that the closures were the result of a confluence of factors including an "[i]nability to compete with more attractive and centralized medical establishments").

[33] *See id.* (stating that the absence of prenatal services east of the Anacostia River creates "another obstacle in a citywide effort to reduce high rates of infant and maternal mortality [in Washington D.C.]").

grave racial disparities in maternal and infant mortality.[34]

Food and income insecurity are also key social determinants of health connected to civil injustice.[35] Income insecurity means that some Americans must choose between buying food or paying other essential bills, such as rent and utilities, leading to dangerous and unhealthy phenomena that have been described as "heat or eat" or "the rent eats first."[36] Lack of nutritious food leads to a number of health concerns including "obesity, low birthrate, iron deficiency, and developmental problems including aggression, anxiety, depression, and attention deficit disorder."[37] According to the D.C. Policy Center, 11% of D.C. is in a food desert, with higher rates in the city's predominantly Black wards (51% of food deserts are located in Ward 8 and 31% in Ward 7).[38] Consequently, Wards 7 and 8 only have four grocery stores in their entire 17.1 square mile area.[39] In comparison, the predominantly white Ward 3 of D.C. has zero food deserts.[40] Moreover, 29.3% of Latinx households with children and 21% of Black households with children reported food insufficiency in April 2021.[41] In contrast, white households with children reported statistically no food insufficiency in April 2021.[42]

Income inequality is also a significant issue in Washington, D.C., where the median household income for white residents is $141,650,

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[34] *See id.* (explaining that the absence of prenatal services east of the Anacostia River creates "another obstacle in a citywide effort to reduce high rates of infant and maternal mortality").

[35] Maureen Black, *Household Food Insecurities: Threats to Children's Well-Being*, AM. PSYCH. ASS'N (June 2012), https://www.apa.org/pi/ses/resources/indicator/2012/06/household-food-insecurities; Cannon, *supra* note 19 at 219–20 (2020).

[36] S*ee* Petersen, *supra* note 19, at 70 ("Soaring rents lead most low-income tenants to spend over half of their income on rent, leading to excruciating budget choices and the inability to afford other basic necessities, such as electricity, water, food, and medicine. As a result, these low-income tenants frequently sacrifice food, medical care, and medications to pay rent."); Cannon, *supra* note 19, at 219–20 ("Food insecurity has cascading effects for low-income Americans; it can force a choice between buying food or paying rent and other important bills, such as utilities payments. This choice, sometimes called "heat or eat," is impossible because people need all of these necessities to thrive.").

[37] Cannon, *supra* note 19, at 219–20; *Food Insecurity,* HEALTHYPEOPLE2030, https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/food-insecurity (last visited Sept. 5, 2023); Maureen Black, *Household Food Insecurities: Threats to Children's Well-Being*, AM. PSYCH. ASS'N (June 2012), https://www.apa.org/pi/ses/resources/indicator/2012/06/household-food-insecurities.

[38] Daniel Ashat, Nicole Tepper & Caroline Pawlow, *An Evaluation of Food Insecurity in the D.C. Community*, 2 GEO. SCI. RSCH. J. 78, 80 (2022).

[39] *Id*.

[40] *Id*.

[41] D.C. OFF. OF PLAN. & D.C. FOOD POL'Y COUNCIL, THE ROAD AHEAD: 2021 UPDATE ON FOOD ACCESS & FOOD SECURITY IN THE DISTRICT OF COLUMBIA 3 (2021).

[42] *Id*.

over three times higher than that of Black residents at $45,072.[43] Furthermore, Black residents are nearly two times as likely to be rent-burdened, meaning that housing costs cut into 30% or more of a household's income.[44] When compared with all racial and ethnic groups, the percent of Black families in poverty is highest at 22%.[45] Unemployment percentages are highest in Wards with the highest proportions of Black residents: Ward 5 (6.9%), Ward 7 (9.7%), and Ward 8 (12.5%).[46]

Black residents are also more likely to work in production, service and sales industries that require manual labor, pay lower wages, and have fewer benefits such as health insurance, paid leave, and retirement plans.[47] Because over 50 percent of service occupations are held by Black residents, Black residents were disproportionately negatively affected by the restricted activity and closure of restaurant and tourism industries during the COVID-19 pandemic.[48]

Educational injustices are also drivers of poor health.[49] Graduation rates are lower for people of color, especially people of color with disabilities,[50] and whether a person graduates high school is a strong predictor of lifelong health.[51] School policing, exclusionary school discipline, and the school-to-prison pipeline, all disproportionately impact Black students, indigenous students, and other students of color, and all harm the health, mental health, and well-being of students.[52]

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[43] Camille Busette & Samantha Elizondo, *Economic disparities in the Washington, D.C. metro region provide opportunities for policy action*, BROOKINGS INST. (Apr. 27, 2022), https://www.brookings.edu/blog/how-we-rise/2022/04/27/economic-disparities-in-the-washington-d-c-metro-region-provide-opportunities-for-policy-action/.

[44] *Id*.

[45] KING & CLOONAN, *supra* note 1, at 10.

[46] *Id.*

[47] *D.C. Racial Equity Profile for Economic Outcomes*, D.C. POL'Y CENTER (Jan. 2021), https://static1.squarespace.com/static/5ffa2eb4a24aef1e5b91c0d6/t/607df46d185dd55abe40f644/1618867332939/.

[48] *Id*.

[49] Yael Cannon & Nicole Tuchinda, *Critical Perspectives to Advance Educational Equity and Health Justice*, 50 J.L. MED. & ETHICS 776, 778 (2022); *Cf.* Thalia González & Paige Joki, *Discipline Outside the Schoolhouse Doors: Anti-Black Racism and the Exclusion of Black Caregivers*, 70 UCLA L. REV. DISCOURSE 40, 42 (2022) (asserting that critical race theory is a "powerful framework in the domain of education justice").

[50] Cannon & Tuchinda, *supra* note 49 at 780 (2022); NAT'L CTR. FOR EDUC. STATS., STUDENTS WITH DISABILITIES 6 (2023), https://nces.ed.gov/programs/coe/pdf/2023/cgg_508.pdf.

[51] Cannon & Tuchinda, *supra* note 49 at 777; S. Jay Olshansky et al., *Differences in Life Expectancy Due to Race and Educational Differences Widening, and Many May Not Catch Up*, 31 HEALTH AFFS. 1803, 1806–07 (2012).

[52] Cannon & Tuchinda, *supra* note 49 at 777;Thalia González, *Race, School Policing, and Public Health*, 73 STAN. L. REV. ONLINE 180, 180 (2021) ("[S]chool policing is an obvious public health issue. It sits at the nexus of two critical social determinants of health — education and racism—and requires targeted attention as such.").

In Washington, D.C., Black students make up 66% of the charter and traditional public school student population, but receive 82% of in-school suspensions, 90% of out-of-school suspensions, and 95% of expulsions.[53] Only 74% of Black students and 68% of Latinx students graduate high school in four years, compared to 94% of white students.[54] When compared with all other races and ethnicities, non-Hispanic Black residents had the lowest percentage (31.1%) of bachelor's degree attainment at age twenty-five and older in Washington, D.C. between 2017 to 2021.[55]

These racial inequities are not limited to Washington, D.C., but are evident around the nation, and all are impacted by law and policy, such as laws in the areas of housing, public benefits, employment, and education.[56] Rectifying these inequities requires the intentional and active pursuit of health justice and the training of future lawyers and health professionals to that end. Racial justice and health justice, which are intertwined, necessitate housing justice, economic justice, educational justice, and other forms of civil justice.[57]

B. Criminal Injustice and Racial Health Inequities

Like our civil legal systems, our criminal legal system contributes to ill-health and other life-threatening racial injustice. America is the most criminally punitive and carceral of any other wealthy nation.[58] Our poor carceral medical system, the structural and social determinants of health, and the punitive harms of the American criminal legal system compound the problems of the other. These American failures hurt people of color most of all, having also been more likely to be subjected to the civil injustices described in the section above.[59] Ad-

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[53] *Education*, DC KIDS COUNT, https://dckidscount.org/education/ (last visited Sept. 5, 2023).

[54] *Id.*

[55] *People 25+ with a Bachelor's Degree or Higher*, D.C. HEALTH MATTERS, https://www.dchealthmatters.org/indicators/index/view?indicatorId=340&localeId=130951&localeChartIdxs=1%7C2%7C4. (last updated Feb. 2023).

[56] *See generally* DAYNA BOWEN MATTHEW, JUST HEALTH: TREATING STRUCTURAL RACISM TO HEAL AMERICA (2022); s*ee also* Sally Magnan, *Social Determinants of Health 101 for Health Care: Five Plus Five*, NAT'L. ACAD. MED. PERSP. 1, 1 (Oct. 9, 2017), https://nam.edu/wp-content/uploads/2017/10/Social-Determinants-of-Health-101.pdf; Yael Cannon, *Closing the Health Justice Gap: Access to Justice in Furtherance of Health Equity*, 53 COLUM. HUM. RGTS. L. REV. 517, 523 (2022).

[57] *See* Foster et al., *supra* note 6.

[58] *See, e.g.,* Wendy Sawyer & Peter Wagner, *Mass Incarceration: The Whole Pie 2023*, PRISON POL'Y INITIATIVE (Mar. 14, 2023), https://www.prisonpolicy.org/reports/pie2023.html.

[59] *See* ELIZABETH HINTON, LESHAE HENDERSON & CINDY REED., VERA INST. OF JUST., AN UNJUST BURDEN: THE DISPARATE TREATMENT OF BLACK AMERICANS IN THE CRIMINAL JUSTICE SYSTEM 2 (2018); Kathryn A. Sabbeth & Jessica K. Steinberg, *The Gender of Gideon*, 69 UCLA L. REV. 1130, 1145-57 (2023) (showing that people of color,

dressing any of these problems are steps towards racial justice. Addressing them all is vital to achieving it.

While medical professionals may know that "those with an incarceration history report higher chronic health problems, lower self-reported health, higher obesity, more infectious diseases, stress-related illness, and psychological disorders," judges and attorneys may not fully understand the repercussions on health of those they incarcerate.[60] So, without sharing that knowledge with the courts, advocates do a disservice to their clients. Yet, most law students do not receive that type of education in law school and medical students do not often learn how they can play a role in addressing these issues, compounding the injustice.

For every year of incarceration, prisoners lose on average two years of their lives.[61] Even once liberated, at the end of their life, people who have been imprisoned are sicker and need more care than their counterparts who have been free. In the District of Columbia, like in many cities, this impacts the Black community, more than any other. While the District's population is around 45% Black, Black individuals make up an overwhelming majority of the jail population.[62] Because D.C. is not a state and does not have its own prison facilities, once a person is sentenced to prison time in a felony case, they are sent to a federal Bureau of Prisons (BOP) facility to serve their sentence.[63]

There are more than 4,000 D.C. residents behind bars in the BOP.[64] More than 11 percent of the prisoners in the BOP are over the age of 55.[65] About 100 District residents live in federal medical prisons.[66] Across BOP facilities, 95% of these District residents forced

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especially Black women, are often disproportionately represented in the civil justice system, as seen in eviction cases, child welfare cases, and certain debt collection cases).

[60] Sebastian Daza, *The Consequences of Incarceration for Mortality in the United* States, 57 DEMOGRAPHY 577, 578 (2020) (examining the long-term association between individual incarceration and mortality in a longitudinal study spanning nearly forty years).

[61] Emily Widra, *Incarceration Shortens Life Expectancy*, PRISON POL'Y INITIATIVE BLOG (June 26, 2017), https://www.prisonpolicy.org/blog/2017/06/26/life_expectancy/.

[62] Malcom B. Morse, *True Justice: The Disturbing Truth About Incarceration in D.C.*, GEO. J. L. & MOD. CRITICAL RACE PERSP. (February 17, 2020), https://www.law.georgetown.edu/mcrp-journal/blog/true-justice-the-disturbing-truth-about-incarceration-in-d-c/.

[63] Martin Austermuhle, *D.C. Inmates Serve Time Hundreds of Miles from Home. Is it Time to Bring Them Back?,* AM. U. RADIO (AUG. 10, 2017), HTTPS://WAMU.ORG/STORY/17/08/10/D-C-INMATES-SERVING-TIME-MEANS-HUNDREDS-MILES-HOME-TIME-BRING-BACK.

[64] D.C. CORR. INFO. COUNCIL, ANNUAL REPORT 2019 2 (2019).

[65] *Statistics on Inmate Age*, FED. BUREAU OF PRISONS, https://www.bop.gov/about/statistics/statistics_inmate_age.jsp (last visited May. 28, 2023).

[66] *Id.*

against their will to live in the Bureau of Prisons are Black.[67] These stark numbers show the racial injustice of the District's legal system.

Food in BOP facilities is high in salt, sugar, and refined carbohydrates.[68] In a survey asking formerly incarcerated individuals about their meals while in prison, sixty-two percent of respondents reported that they rarely or never had access to fresh vegetables while incarcerated.[69] The commissary food available for purchase is even worse, with no fresh food available at all.[70] Furthermore, the partnerships with private food service providers has lowered food quality standards as a result of cost cutting efforts to maximize efficiency at a lower cost.[71] These low-quality, high-calorie foods are a cheaper yet inadequate alternative to nutritionally dense food, which contribute to the elevated rates of diabetes and heart disease among the incarcerated population.[72]

Studies show these nutritional deficiencies also cause declines in an incarcerated individual's mental health, citing a link between persistent malnutrition and depression, aggression, and antisocial behavior.[73] Moreover, the standards for medical treatment of prisoners are very low. Similarly to food service provision, prison health care providers in the BOP, and in state prisons more broadly, have increasingly prioritized efficiency at the expense of prisoners' access to quality medical care.

Medical treatment in the BOP is subpar.[74] There are no standards

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[67] Rachel Weiner & Justin Wm. Moyer, *Inmates from D.C., who are mostly Black, fare worse prison conditions*, WASH. POST (February 8, 2022; 11:46 AM), https://www.washingtonpost.com/dc-md-va/2022/02/08/bop-lawsuit-dc-inmates/#.

[68] Jessica Carns & Sam Weaver, *Two Cups of Broth and Rotting Sandwiches: The Reality of Mealtime in Prisons and Jails*, ACLU NEWS AND COMMENT. (Nov. 23, 2022), https://www.aclu.org/news/prisoners-rights/the-reality-of-mealtime-in-prisons-and-jails#:~:text=the%20typical%20prison%20diet%2C%20which,illness%20than%20the%20general%20population.

[69] *Eating Behind Bars: Ending the Hidden Punishment of Food in Prison*, IMPACT JUST. (2020), https://impactjustice.org/wp-content/uploads/IJ-Eating-Behind-Bars-Executive Summary.pdf (describing the scarcity of fresh and nutritious foods available in prisons).

[70] Stephen Raher, T*he Company Store: A Deeper Look at Prison Commissaries,* PRISON POL'Y INITIATIVE (May 2018), https://www.prisonpolicy.org/reports/commissary.html.

[71] *Eating Behind Bars: Ending the Hidden Punishment of Food in Prison*, *supra* note 72 (explaining how the systematic slashing of prison food budgets on a national scale have resulted in a widespread deterioration in the quality of food).

[72] *Id.* (prison food consumption long term causes rises in cholesterol and body fat and other diet-related diseases).

[73] *Id.* (Research shows that the nutritional deficiencies in prisons can result in "an increased risk of diet-related diseases", immune suppression issues "making incarcerated people more vulnerable to viruses such as Covid-19" and contribute to "a wide range of mental health and behavioral issues.").

[74] Walter Pavlo, *Federal Bureau of Prisons' Medical Care Falls Short of its Own* Policy, FORBES (Apr. 19, 2022; 11:41 PM);https://www.forbes.com/sites/walterpavlo/2022/04/19/

for the timely delivery of care and facilities are plagued with serious staffing shortages that impact prisoners' access to medical care.[75] With Black citizens more likely to be caged behind bars, and the BOP's terrible record of delivery of care, it is unsurprising that life expectancy is shorter for Black residents and those who spend time in prison.

The next generation of leaders in law and health need to understand the connections between criminal, health, and racial injustice and learn to advocate and collaborate to address those injustices. Academic MLPs are in a unique position to advance this important mission at both an individual and structural level. Freeing the people trapped in this racist and punitive system is imperative to their health and to racial justice. To that end, the American Public Health Association has advocated for abolition of the carceral system as an important public health strategy.[76] Because racial disparities in health and the carceral system stem from centuries of oppression, legal scholars like Amna Akbar have argued that individual-level advocacy will not suffice to address "structural and historically rooted" issues.[77] As one interdisciplinary team of MLP scholars put it, "carceral exposure . . . has a significant negative impact on . . . health and well-being. . ."[78]

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federal-bureau-of-prisons-medical-care-falls-short-of-its-own-policy/?sh=46a8662b5eab.

[75] Keri Blakinger, *Prisons Have a Health Care Issue– And it Starts at the Top, Critics Say*, THE MARSHALL PROJECT (July 01, 2021; 6:00 AM), https://www.themarshallproject.org/2021/07/01/prisons-have-a-health-care-issue-and-it-starts-at-the-top-critics-say (2021).

[76] *Advancing Public Health Interventions to Address the Harms of the Carceral System*, AM. PUB. HEALTH ASS'N (Oct. 24, 2020), https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2021/01/14/advancing-public-health-interventions-to-address-the-harms-of-the-carceral-system; ERNEST DRUCKER, A PLAGUE OF PRISONS: THE EPIDEMIOLOGY OF MASS INCARCERATION IN AMERICA 163 (2d ed. 2013) ("To employ a public health model of prevention we must also think beyond the usual clinical model of care that is premised on'fixing what is broken' in the individual case. In the public health approach we need to consider each part of the epidemiological triad—not just the host—by reducing exposure to the harsh punishment of imprisonment.").

[77] Amna A. Akbar, *An Abolitionist Horizon for (Police) Reform*, 108 CAL. L. REV. 1781, 1839 (2020) ("Mass incarceration and broken-windows policing are only decades-old phenomena, while racialized modes of exploitation, dispossession, and confinement have existed since at least the dawn of colonialism and enslavement."); *Advancing Public Health Interventions to Address the Harms of the Carceral System,* AM. PUB. HEALTH ASS'N (Oct. 24, 2020), https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2021/01/14/advancing-public-health-interventions-to-address-the-harms-of-the-carceral-system ("While efforts to improve health conditions both during and after incarceration are important, they do not address the root causes of incarceration or prevent the associated negative health consequences. . . . Abolition requires that we take a critical approach and investigate the root cause of the various levels of policy and the ingrained frameworks that limit our conceptions of—and responses to—safety, punishment, and violence.").

[78] Nicolas Streltzov, Ella van Deventer, Rahul Vanjani & Elizabeth Tobin-Tyler, Article, *A New Kind of Academic MLP: Addressing Clients' Criminal Legal Needs to Promote*

Improving prison conditions or even medical care in prisons is insufficient to address health inequities because physical incarceration has powerful negative impacts on health.

The early exposure that A-MLPs provide to law and medical students of the realities of the criminal, health, and racial injustice nexus creates a formative experience for these new professionals, which can counteract the siloing and traditional status quo of their industries. Through their firsthand experiences, law and medical students also gain insight into the importance of linking clinical experiences to efforts for expansive and radical social change. With this education, the next generation of legal and health leaders will be prepared to push for structural reform in concert with their client/patient advocacy.[79]

II. Interprofessional Academic Medical-Legal Partnership Advocacy to Advance Health and Racial Justice Across Civil and Criminal Legal Advocacy

A. Academic Medical-Legal Partnerships (A-MLPs)

Medical-legal partnerships (MLPs) provide an important vehicle for the advancement of health justice and racial justice.[80] MLPs integrate lawyers onto healthcare teams to address health-harming legal needs.[81] In a traditional MLP, lawyers train physicians and other healthcare professionals to identify unmet legal needs that impact health and refer patients to the attorney team for legal assistance.[82] The attorneys and healthcare providers collaborate to address those legal needs, with attorneys helping the healthcare team understand laws that serve as determinants of health and the legal rights of their patients, and the healthcare team lending information and expertise in support of legal advocacy.[83] MLPs also engage in patients-to-policy advocacy, which involves the identification of gaps and problems with

Health Justice and Reduce Mass Incarceration, J.L. Med. & Ethics (forthcoming 2024) (manuscript at 3) (on file with authors).

[79] Megan Sandel, Mark Hansen, Robert Kahn, Ellen Lawton, Edward Paul, Victoria Parker, Samantha Morton & Barry Zuckerman, *Medical-Legal Partnerships: Transforming Primary Care By Addressing the Legal Needs of Vulnerable Populations*, Health Affs. Blog (Sept. 2010), https://www.healthaffairs.org/doi/10.1377/hlthaff.2010.0038 (describing the "patients to policy" model of MLPs).

[80] Cannon, *supra* note 56, at 561–62 (2022).

[81] *Id*. at 61; Elizabeth Tobin Tyler & Joel B. Teitelbaum, *Medical-Legal Partnership: A Powerful Tool for Public Health and Health Justice*, 134 Pub. Health Rep. 201, 203 (2019).

[82] Cannon, *supra* note 19 (2020), at 265 (2020); *The Response*, Nat'l Ctr. For Med. Legal P'ship, https://medical-legalpartnership.org/response/ (last visited Sept. 5, 2023).

[83] Cannon, *supra* note 14 (2023), at 78 (2023).

the law that necessitate systemic change and advocacy to pursue necessary reforms.[84]

A-MLPs are based in university settings and engage pre-professional learners in interprofessional MLP learning environments that are often experiential.[85] They can also leverage their roles within research institutions to develop research and scholarship to study the impact of MLP advocacy and teaching and to explore the connections between health and justice.[86] Many A-MLPs are housed in law school clinics, where law students partner with medical, nursing, social work, public health, or other health profession students and professionals in seminars, case rounds, and/or casework on behalf of clients with low-income.[87] Some A-MLPs also use the patients-to-policy advocacy approach to engage in work towards systemic reform.[88]

MLPs have traditionally engaged in civil advocacy on behalf of clients. The National Center for MLP has put forth the I-HELP framework to capture the types of health-harming civil legal needs most often encountered and addressed by civil legal aid, which include Income, Housing & Utilities, Education & Employment, Legal Status, and Personal & Family Stability.[89] The only criminally-related legal issue explicitly included on the I-HELP chart is the clearing of criminal histories, through efforts such as sealing and expungement of criminal records, in the Legal Status category.[90] Traditionally, criminal justice-related advocacy was not within the purview of MLPs, most of which involve civil legal advocacy by legal aid organizations or law

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[84] Yael Cannon, *Unmet Legal Needs as Health Injustice*, 56 U. RICH. L. REV. 801, 862 (2022).

[85] *See* VICKI W. GIRARD, DEBORAH F. PERRY, LISA P. KESSLER, YAEL CANNON, PRASHASTI BHATNAGAR & JESSICA ROTH, THE ACADEMIC MEDICAL-LEGAL PARTNERSHIP: TRAINING THE NEXT GENERATION OF HEALTH AND LEGAL PROFESSIONALS TO WORK TOGETHER TO ADVANCE HEALTH JUSTICE, NAT'L CTR. FOR MED.-LEGAL P'SHIP 5, 15 (2022); *see* Edward B. Healton, William M. Treanor, John J. DeGioia & Vicki W. Girard, *Training Future Health Justice Leaders – A Role for Medical-Legal Partnerships*, 384 NEW ENG. J. MED. 1879, 1880 (2021).

[86] VICKI W. GIRARD et al., *supra* note 85, at 18.

[87] *Id.* at 12.

[88] Cannon, *supra* note 84, at 847 (2022); *see generally* Deborah N. Archer, *Political Lawyering for the 21st Century*, 96 DENV. L. REV. 399 (2019) (describing a practice of political lawyering through which lawyers can "tackle both new and chronic issues of injustice through a broad array of advocacy strategies").

[89] Marple, *supra* note 15.

[90] MARSHA REGENSTEIN, JENNIFER TROTT & ALANNA WILLIAMSON, THE STATE OF THE MEDICAL-LEGAL PARTNERSHIP FIELD 15 (2017) (explaining that "I-HELP™ is a system of categories designed by the National Center for Medical-Legal Partnership to capture the types of health-harming civil legal needs most often encountered and addressed by civil legal aid. The I-HELP™ categories are defined as Income and insurance, Housing and utilities, Education and employment, Legal status, and Personal and family stability."); *see also* Marple, *supra* note 15.

school clinics.[91] This Article argues that the Academic Medical-Legal Partnership model provides an important opportunity to advance racial justice by training the next generation of lawyers, doctors, and other healthcare professionals not only to address the civil legal determinants of health, but to address the criminal legal determinants of health as well.

B. MLP Advocacy to Advance Racial Justice Across Civil and Criminal Spheres

It was not until the COVID-19 pandemic that Georgetown Law's two criminal law clinics recognized that the MLP model could benefit clients. Through the experience of litigating compassionate release cases with clinical law students that involved review of and arguments about clients' medical records, these clinics realized that criminal defense expertise was not sufficient to provide excellent delivery of legal services. Faculty in the criminal clinics reached out to the already-existing Health Justice Clinic (HJA) A-MLP at Georgetown for help connecting with faculty at Georgetown's medical school who already worked with HJA. The partnership between the medical school and the law school grew to include criminal legal advocacy, helping the partners in both schools see how A-MLPs could advance health and racial justice through advocacy in civil and criminal legal systems.

MLPs focused on health and the criminal legal system are rare. Of the over 400 medical-legal partnerships around the country, the vast majority focus on civil legal issues.[92] Development of the traditional MLP model stemmed from the understanding that low-income Americans were not guaranteed assistance of counsel in civil matters.[93] A new MLP approach is beginning to emerge to address crimi-

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[91] REGENSTEIN ET AL., *supra* note 90, at 10 (finding that of MLP legal respondents to a survey by the National Center for Medical-Legal Partnership, three-quarters were a civil legal aid organization and one-fifth were a law school clinic), 15-16 ("[e]ighty-nine (89) percent of MLP civil legal organizations received referrals from health care partners for income and insurance needs, 88 percent had referrals for housing and utilities needs, and 92 percent had referrals related to personal and family stability. Slightly fewer reported referrals for education and employment needs (83 percent) or needs related to legal status (68 percent).").

[92] *The Response*, NAT'L CTR. FOR MEDICAL-LEGAL P'SHIP, https://medical-legalpartnership.org/response (last visited June 15, 2023).

[93] Rahul Vanjani, Sarah Martino, Sheridan F. Reiger, James Lawless, Chelsea Kelly, Vincent J. Mariano & M. Catherine Trimbur, *Physician-Public Defender Collaboration- A New Medical-Legal Partnership*, 383 NEW ENG. J. MED. 2083, 2084 (2020) (explaining that the MLP model stemmed from "the understanding that in the United States low-income people have no guarantee of assistance in civil matters." Despite efforts from Congress to establish the Legal Services Corporation, " a private 501(c)(3) organization that distributes federal funding to civil legal aid organizations. . .. There is not enough funding. . ..to meet the high demand for civil legal services.").

nal legal needs in addition to civil legal needs.[94] Incorporating this model into academic MLPs, where future lawyers and health professionals can learn to practice differently, provides a critical opportunity for holistic advocacy to advance racial justice for people involved in the criminal legal system.

While most academic MLPs focus on civil rather than criminal legal advocacy, some have focused their *civil* legal advocacy on people involved in the juvenile delinquency or criminal legal systems. For example, the University of New Mexico Medical-Legal Alliance provides civil legal advocacy, along with health, behavioral health, educational and other non-legal services delivered through partner health clinics, to help at-risk youth stay out of detention.[95] Yale Law school has an A-MLP with the Yale-New Haven Hospital working to keep returning citizens out of the legal system through the delivery of civil legal assistance.[96] Focusing on the civil justice issues that determine whether a person ends up in or cycles back into the carceral system is important advocacy to advance racial justice.

Some non-academic MLPs have recently begun to advocate around criminal legal issues. MLPs in Boston, Massachusetts[97] and Rhode Island are based out of public defender offices that collaborate with physicians to address common health-related social and legal needs.[98] The partnership between the Rhode Island Public Defender's office and the Lifespan Transitions Clinic (LTC), a primary care program within the Rhode Island Hospital Center, is an example of this emerging approach to MLPs.[99] The MLP in Boston advocates on behalf of their clients by asking doctors to write medical affidavits for use in persuading decision makers to consider their client's medical

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[94] *MLP in Health Centers Guide Webinar Series Part 4: The Medical-Public Defender Partnership,* NAT'L CTR. FOR MEDICAL-LEGAL P'SHIP (June 28, 2022) https://medical-legalpartnership.org/mlp-resources/medical-public-defender-partnership.

[95] Julia Sclafani, *From Detention to Deliverance*, SEARCHLIGHT NEW MEXICO (Oct. 21, 2020), https://searchlightnm.org/from-detention-to-deliverance.

[96] *Medical-Legal Partnerships*, SOLOMON CTR. FOR HEALTH L. & POL'Y AT YALE L. SCH., https://law.yale.edu/solomon-center/projects-publications/medical-legal-partnerships (last visited Sept. 5, 2023).

[97] Press Release, "Our Patients Our Clients" (OPOC), collaboration between Boston's public defenders and the Internal Medicine Residency at Brigham and Women's Hospital (2023) (on file with author).

[98] Streltzov et al, *supra* note 78, at 5-6; Vanjani et al., *supra* note 93, at 2085 (discussing a new partnership between Rhode Island Public Defenders and a primary care medical program).

[99] Streltzov et al, *supra* note 78, at 5-6; Vanjani et al., *supra* note 93, at 2085 ("Despite a shared mission of caring for people at their most vulnerable, collaboration between public defenders and health care providers in aiding low-income people has not historically been formalized in MLPs.") .

conditions while they decide the issue of punishment.[100]

While traditional MLPs address many of the civil issues that disproportionately affect patients with involvement in the criminal justice system, this type of MLP model takes the advocacy one step further, citing that the academic medical literature has "generally focused on screening and treatment among populations with such involvement, rather than on preventing incarceration itself, as part of an achievable or even tenable treatment plan."[101] This medical-public defender partnership works by creating an open field of communication between physicians and public defenders.[102] For public defenders, medical information serves as valuable evidence in advocating to keep their client out of prison.[103] Many patients involved in this program respond positively to having their physician involved in their legal process, as it affords patients additional opportunities to discuss their case or provide documentation that can positively affect outcomes.[104] Proponents of this model state that unlike certain forms of structural inequality that traditional MLPs address such as homelessness and food insecurity, incarceration itself as a determinant of poor health has not "entered the standard medical lexicon."[105] While these medical-public defender examples are not academic MLPs, their success speaks to the benefits of integrating MLPs beyond civil advocacy.

Despite the fact that healthcare providers have become more aware of the ways that involvement in the criminal justice system negatively impacts patients' health, physicians are understandably limited in their ability to address these issues in their capacity as health care providers. MLPs that engage in both civil and criminal advocacy are a

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[100] Kate Marple, *Framing Legal Care as Health Care*: *How Legal Services Can Address the Social Determinants of Health*, NAT'L CTR FOR MED. LEGAL-P'SHIP (2015), https://medical-legalpartnership.org/wp-content/uploads/2014/02/How-Legal-Services-Help-Health-Care-Address-SDOH-August-2017.pdf.

[101] Vanjani et al., *supra* note 93, at 2084; Streltzov et al., *supra* note 78, at 4) (proposing that medical-legal partnerships can "serve as a vital intervention to prevent or reduce criminal system involvement, while also addressing social and structural determinants of health").

[102] Vanjani et al., *supra* note 93, at 2084.

[103] Streltzov et al., *supra* note 78, at 10 ("In numerous instances, judges reported being moved by the medical reports to reduce or completely spare incarceration due to consideration of the individual's health."); Vanjani et al., *supra* note 93, at 2085 (explaining how this medical-public defender partnership enables doctors and attorneys new and effective ways to advocate for the communities that they serve).

[104] Vanjani et al., *supra* note 93, at 2086-88 (describing how this partnership has assisted patients living with substance use disorders who are prone to have a long history in the criminal justice system).

[105] Vanjani et al., *supra* note 93, at 2085 (describing a "growing awareness [amongst physicians] that incarceration and community supervision hinder patients' attainment of stable housing, meaningful employment, medication adherence and other determinants of health").

collaborative solution to this gap that has potential to reduce harm in communities and improve health outcomes.

By approaching criminal cases and incarceration as obstacles to health, and using their client's medical information as evidence of injustice, defense lawyers in MLPs impart a new framework for judges and the legal system to evaluate the utility of various forms of punishment and rehabilitation. Medical providers impact their patient's health outside of prescribing medication and giving advice through the medical expertise shared with the legal system through the MLP, thus impacting their patient's health in a substantial way. In particular, *academic* MLPs are uniquely positioned to advance racial justice by training lawyers and doctors to take this new approach through collaborative advocacy before their careers even start.

1. A-MLP Civil Advocacy

Academic MLPs have long been engaged in civil legal advocacy. Early university-based MLPs involved law school clinics at University of New Mexico, Georgia State, and other law schools advocating to address civil legal issues facing patients of their medical partners in areas such as housing, family, education, and public benefits law.[106] While MLPs that address civil legal needs, including academic MLPs, have traditionally framed their work through the lens of poverty, scholars are increasingly calling on MLPs to explicitly work to advance racial justice, especially given the structural racism that drives both health inequities and civil injustice and the histories of racism in both medical and legal systems. In training the next generation of doctors, lawyers, and other health professionals, A-MLPs provide a unique opportunity to advance racial justice by educating learners during a critical formational period prior to launching their careers.

In an A-MLP, students from law, medicine, and other health disciplines can learn about the complicated and compounding nature of the issues facing clients as a result of structural racism, the intersecting identities of many clients, and the need for intentional approaches that advance justice on multiple fronts.[107] For example, in the Health Justice Alliance Law Clinic at Georgetown University Law Center, law and medical students learn about approaches from critical race

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[106] Vicki W. Girard, Yael Z. Cannon, Deborah F. Perry & Eileen S. Moore, *Academic Medical-Legal Partnerships: Centering Education and Research to Help Advance Health Justice*, J.L. Med. & Ethics (forthcoming 2023) (manuscript at 5) (on file with authors).

[107] *See* Healton et al., *supra* note 85, at 1880; *Georgetown's Health Justice Alliance Unites Law and Medical Centers to Advance Health Equity* [Hereinafter *Georgetown's Health Justice Alliance*], GEO. L.: NEWS (May 19, 2021), https://www.law.georgetown.edu/news/georgetowns-health-justice-alliance-unites-law-and-medical-students-to-advance-health-equity/.

theory and other critical legal studies, such as intersectionality and counternarratives,[108] which help them to understand important contexts surrounding the issues they are confronting in their casework.[109] They learn about structural racism embedded in the laws, policies, and systems in which they are operating, such as the racist tropes that shaped welfare reform in 1996 and the ramifications of pro-gentrification policies on communities of color.

Students develop interdisciplinary collaboration skills as part of the intentionally antiracist pedagogy.[110] They experience the process and product of including a "legal check-up" as part of a medical appointment that recognizes that the structural and social determinants are the primary drivers of health and to see the role that law plays in driving health inequities.[111] The students learn to identify problems holistically and to see their clients as people, rather than legal issues or medical diagnoses, who are in need of holistic advocacy to resolve intertwined issues.[112]

Moreover, students learn to help clients understand where the challenges they are facing actually implicate legal rights and have legal remedies, which is important to building the power of clients to self-advocate and assert their rights in the long-term within systems that often subordinate people of color.[113] Through low-barrier access to justice that includes proactive legal screening in the familiar setting of a pediatrician's office, law and medical students learn how legal advocacy can prevent crises, including preventing entry into systems that cause racialized violence, such as eviction courts, the family regulation system, and the school-to-prison pipeline.[114] For example, by screening for and identifying public benefits, housing voucher, and housing conditions legal issues for families struggling to pay rent, the HJA Law Clinic can advocate for increased benefits and rental assistance and remediation of substandard housing conditions. Such advocacy can work upstream to prevent outcomes of racial injustice, such as by

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[108] Cannon & Tuchinda, *supra* note 49 at 778 (citing Richard Delgado, *Storytelling for Oppositionists and Others: A Plea for Narrative*, 87 MICH. L. REV. 2411, 2438, 2415 (1989)).

[109] *See* Michelle S. Jacobs, *People from the Footnotes: The Missing Element in Client-Centered Counseling*, 27 GOLDEN GATE U. L. REV. 345, 346-48 (1997); Richard Delgado, *Storytelling for Oppositionists and Others: A Plea for Narrative*, 87 MICH. L. REV. 2411, 2437-40 (1989).

[110] *See* Anna Louie Sussman, *Stronger Together*, GEO. L., Spring/Summer 2020, at 50, 54.

[111] *See* Healton et al., *supra* note 85, at 1881; Vicki Girard, Yael Canon, Prashasti Bhatnagar & Susan Coleman, *How Medical-Legal Partnerships Help Address the Social Determinants of Mental Health*, 35 ARCHIVES PSYCHIATRIC NURSING 123, 125 (2021).

[112] *See* Cannon, *supra* note 14 at 78 (2023).

[113] *See id.*

[114] *See id.* at 82-83.

serving to prevent evictions,[115] which disproportionately impact Black women and cause tremendous harms to the health and mental health of families of color.[116]

Law and medical students also learn to engage in a "patients-to-policy" approach through which they identify gaps and problems with the law and advocate for systemic reform that advances racial justice. For example, after representing families whose children had been lead poisoned in rental homes with substandard housing conditions, law and medical students testified before the D.C. Council to advocate for legislation that would prevent lead exposure and provide more accountability for landlords to address a systemic problem that disproportionately affects Black children in Washington, D.C., with grave harms to their health and development.[117] Students also learn to build the power of clients and communities to drive and advance a health justice agenda by preparing their clients for legislative testimony and connecting them with grassroots organizations mobilizing to advocate for law and budget reforms that advance racial justice in a city where racial inequities abound.[118]

A-MLPs are uniquely positioned to promote racial justice by training future lawyers and health professionals to approach their work differently before their careers even start, while their professional identities, values, skills, and knowledge base are still in formation.

2. A-MLP Criminal Advocacy

Criminal legal advocacy provides a new frontier for the advancement of racial justice by MLPs—and for A-MLPs in particular. Georgetown University Law Center's criminal clinics seized on this opportunity during the COVID-19 pandemic by building on the work of Georgetown's Health Justice Alliance and joining that existing partnership in A-MLP collaboration to advance racial justice through criminal legal advocacy. Litigating the federal First Step Act's compassionate release provisions and the D.C. Compassionate Release statutes placed medical records of long-serving prisoners in the Bureau of Prisons into the hands of lawyers and judges outside prison walls.[119] Both statutes allow judges to revisit long prison sentences of

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115 *Id.* at 74.

116 Sabbeth & Steinberg, *supra* note 59 at 1147-48.

117 *See* Sussman, *supra* note 113, at 50, 60; Healton et al., *supra* note 85, at 1881; *Georgetown's Health Justice Alliance*, *supra* note 110.

118 *See* Yael Cannon, *Equipping the Next Generation of Health Justice Leaders*, HARV. L. SCH. PETRIE FLOM CTR. BLOG (Sept. 20, 2021), https://blog.petrieflom.law.harvard.edu/2021/09/20/health-justice-leaders/.

119 Ann E. Marimow, *Sick, Elderly Prisoners are at Risk for Covid-19. A new D.C. Law*

elderly and sick people who are still forced to live behind bars.[120] These statutes, and similar ones across the country, gave the legal community an opportunity to address the suffering of the vulnerable incarcerated community who have no choices with respect to their medical care or the food they eat.

Initially, much of the litigation of compassionate release motions was focused around removing older prisoners and those with medical conditions from crowded prisons so they might avoid contracting COVID-19.[121] Thousands of petitions were filed on behalf of people serving sentences in the BOP.[122] Over 4000 federal prisoners were released by judges under the federal First Step Act compassionate release provision.[123] Over 200 people have been released by the D.C. Superior Court under D.C.'s compassionate release statute.[124] Dozens of those released were represented by Georgetown's criminal clinics.[125]

Georgetown Law's criminal clinics' students and post-graduate fellows began filing compassionate release motions on behalf of District of Columbia residents serving sentences in the Bureau of Prisons in 2020. The law students and the clinical law faculty had no medical training and it quickly became apparent that high quality legal work on compassionate release cases required medical expertise, and a partnership between the criminal clinics and the medical school began.

Criminal clinic students at Georgetown started to participate in the relationship during the 2020-2021 school year and it has continued in the years since. It may be the first MLP within a law school criminal defense clinic. The relationship between the Health Justice Alliance, the criminal clinics and the medical school has underscored that

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Makes it Easier for them to Seek Early Release, WASH. POST (Dec. 30, 2020), https://www.washingtonpost.com/local/legal-issues/sick-elderly-inmates-coronavirus-release/2020/12/29/5342816c-3fcd-11eb-8db8-395dedaaa036_story.html; *see also,* Laetitia Haddad, *Law Students Win Compasionate Release for Clients Through GULC Clinics,* THE HOYA (Apr. 23, 2021), https://thehoya.com/law-students-win-compassionate-release-for-clients-through-gulc-clinics/.

120 18 U.S.C. § 3582 (c)(2) (2018)(Imposition of a Sentence of Imprisonment for Sentencing Relief); D.C. CODE § 24-403.04 (2021)(Motions for Compassionate Release for Individuals Convicted of Felony Offenses).

121 Benjamin A. Barsky, Sunny Y. Kung & Monik C. Jiminez, *Covid-19, Decarceration, and Bending the Arc of Justice- The Promise of Medical-Legal Partnerships*, HEALTH AFFS. BLOG (May 28, 2021), https://www.healthaffairs.org/content/forefront/covid-19-decarceration-and-bending-arc-justice-promise-medical-legal-partnerships.

122 U.S. SENT'G COMM'N, COMPASSIONATE RELEASE DATA REPORT 4 (2022).

123 *Id.* at Table 1.

124 Records on file with authors.

125 As of the writing of this paper, the Georgetown clinic students and E. Barrett Prettyman fellows have secured the release of more than 40 men. Records on file with authors.

MLPs can be fruitful across legal disciplines and impact client outcomes, including judicial decisions, in both civil and criminal cases, as well as student learning in ways that advance health and racial justice.

The partnership with medical faculty and students has shown the Georgetown Law criminal clinics and faculty that justice is not possible in any sphere, especially racial justice, without health justice. The collaboration has meant freedom for dozens of criminal clinic clients—elderly and sick men. Clients have been reunited with their families and communities before the end of their lives—something many of them thought would never happen. Clients have been connected with renal specialists, oncologists, and other specialists once they have been released into the community, often after decades of incarceration. Almost every single client was African American. Maybe most importantly, the Georgetown Law criminal clinics have had the opportunity to educate D.C.'s bench about the health impacts of prison, and have educated medical and law students—future leaders in medicine and law—alike.

Once a week, fourth-year medical students and a medical school professor meet with third year law students, fellows and faculty in the criminal clinic to review medical records provided by the Bureau of Prisons in connection with legal representation of clients on motions for compassionate release. These "case rounds" allow for education across disciplines, for law students to have the experience of working with experts outside of law, and for medical students to review medical records kept by a prison and see the impacts of prison on the human body. In a few instances, the medical school supervisor has even assumed temporary medical care for sick clients who get released from prison while an appropriate physician is identified.

The partnership also gives each medical student the opportunity to deliver a lecture (supervised and evaluated by a medical faculty partner) once a month on a relatively common health condition among our client population like—heart disease, hepatitis, kidney disease, eye disorders—that are uploaded to a medical library accessible to the law students and faculty. This has increased medical knowledge for everyone.

Many in the public health and medical communities have long known that a person's zip code is more important than their genetic code in determining health outcomes.[126] It is understood that the social determinants impact an individual's health in many ways. Factors

[126] Garth Graham, MaryLynn Ostrowski & Alyse Sabina, *Defeating the ZIP Code Health Paradigm: Data, Technology, and Collaboration Are Key*, HEALTH AFFS. BLOG (Aug. 6, 2015), https://www.healthaffairs.org/content/forefront/defeating-zip-code-health-paradigm-data-technology-and-collaboration-key.

like where a person lives, grows up, attends school, and whether they have experienced trauma can all impact a person's health. This is certainly true of prisons.

The medical school partners found expected health issues in almost all of the clients, which is unsurprising, since these incarcerated clients were asking for compassionate release. But medical partners also identified health issues that had not been identified by the prison medical staff. Students were able to help clients get more appropriate care even if they were not released from prison.

The fact that most of the compassionate release clients served by the Georgetown Law criminal clinics have been Black people is a reflection of the population of indigent D.C. residents in the Bureau of Prison serving long sentences and the existing racism in our legal system and other institutions. Therefore, the curriculum for the Georgetown law criminal clinic students includes the topic of race and/or racism in nearly every conversation–whether it is with respect to a racist algorithm used to identify kidney disease by the BOP (and many other medical providers),[127] explicit racial bias by police, prosecutors and judges, or in conversations about the Fourth Amendment. The curriculum and conversations in seminar deepen the learning that students receive in the field and through the collaboration.

Georgetown's medical-legal partnership so far has only served clients on requests for release from the federal Bureau of Prisons under the District of Columbia's compassionate release statute.[128] While this criminal MLP is focused on post-conviction release, MLPs in defender offices and law school criminal defense clinics can be used not only to get sick and elderly people out of prison, but to advocate for alternatives to pre-trial detention and incarceration, to address how all conditions of confinement harm health, and to help address substance abuse, psychiatric issues, head injuries, birth injuries, and pain management as well. They can also work interdisciplinarily towards systemic reform of the carceral system and the broader criminal legal system.

Hopefully, the emerging model of public defender MLPs and A-MLPs, such as the one at Georgetown University, will broaden the reach of these alliances across systems. As Georgetown criminal clinic law students who go on to public defender offices and other legal and

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[127] Rae Ellen Bichell & Cara Anthony, *For Black Kidney Patients, an Algorithm May Help Perpetuate Harmful Racial Disparities*, WASH. POST (June 6, 2021), https://www.washingtonpost.com/health/black-kidney-patients-racial-health-disparities/2021/06/04/7752b492-c3a7-11eb-9a8d-f95d7724967c_story.html.

[128] D.C. CODE § 24-403.04 (2021) (Motions for Compassionate Release for Individuals Convicted of Felony Offenses).

policy settings and the medical students graduate and become physicians, they can build on their MLP experience and work to advance health and racial justice in criminal and other legal spheres, helping individuals achieve justice and transforming health and legal systems and structures.

III. A-MLP Advancement of Racial Justice

Law school clinics engaged in A-MLP advocacy are uniquely situated to advance racial justice. Seminars, case rounds, experiential learning, and client cases offer opportunities to advance racial justice across criminal and civil legal spheres. Given the work that the authors have done developing companion A-MLPs at the same law school in both civil and criminal law school clinics, the collaboration has allowed for sharing inspiration drawn from our attempts to make these clinics springboards for racial justice. This Article argues that A-MLPs are well-positioned to advance racial justice not only through civil legal advocacy, but through criminal legal advocacy as well. This section examines specific approaches that A-MLPs should adopt in order to promote racial justice across civil and criminal legal advocacy.

A. Naming and Centering Racial Justice and Anti-Racist Advocacy

A-MLPs across the civil and criminal spheres should begin their racial justice work by explicitly naming and framing their racial justice missions and centering anti-racism in their work.[129] A-MLP scholar and law clinic professor Medha Makhlouf has argued that a focus on structural racism has been traditionally absent from the MLP movement, with poverty instead most commonly serving as the focal point.[130] The poverty focus results from longstanding perspectives of legal services and healthcare, and has the potential to reinforce structural inequality.[131] With a singular focus on poverty, MLPs risk overlooking the structural racism in our institutions that underlies disparities in health.[132] Given that racial disparities in health, housing, education, and the criminal legal system persist even when controlling for socioeconomic status,[133] a poverty orientation is inadequate to

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[129] Medha Makhlouf, *Addressing Racism through Medical-Legal Partnerships*, Harv. L. Sch. Petrie-Flom Ctr. Blog (September 24, 2020), https://blog.petrieflom.law.harvard.edu/2020/09/24/addressing-racism-medical-legal-partnerships/.

[130] Medha D. Makhlouf, *Towards Racial Justice: The Role of Medical-Legal Partnerships*, 50 J. L. Med. & Ethics 117, 119 (2022); Girard et al., *supra* note 106, at 12.

[131] *See* Makhlouf, *supra* note 130, at 119.

[132] *See* Makhlouf, *supra* note 130, at 121.

[133] *See* Dina Shek, *Centering Race at the Medical-Legal Partnership in Hawai'i*, 10 U. Mia. Race & Soc. Just. L. Rev. 109, 114 (2019); Makhlouf, *supra* note 130 at 118 ("Sys-

provide the foundation needed for MLP advocacy in pursuit of health justice. In a society where many are in denial of both the existence and ubiquity of racism, naming it is particularly critical.[134]

Similarly, A-MLP scholar and law clinic professor Dina Shek has argued that MLPs must work explicitly to combat structural racism so that they do not unintentionally "uphold and legitimize the structures that maintain institutional racism."[135] Failing to specifically recognize racism also undermines the goal of MLPs to affect transformational change—and risks creating regular clients as opposed to building the power of clients as self-advocates.[136] An intersectional approach centering structural racism, rather than limiting the scope to poverty can ensure that MLPs are not creating returning clients, but rather increasing collective power and dismantling racial injustice perpetuated by legal and medical systems.[137]

Naming and framing the work of MLPs through the lens of racial justice is also important because racial health inequity is a "wicked problem," or a problem that is interdisciplinary, deep-rooted, chronic, and unremitting, with multiple sources.[138] Wicked problems require attention to the structures at their root that contribute to their longevity.[139]

Such an approach requires going beyond traditional framing of criminal defense or civil legal advocacy work and naming and framing racial justice as a core value and goal of A-MLP work. An explicit anti-racist focus and acknowledgement of structural racism can deepen interprofessional student learning about health equity and health justice.[140] For example, A-MLP faculty at Loyola Law School recently introduced a new interprofessional course for law, medical,

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temic health differences by race and ethnicity in the United States are the fruits of structural racism. . .."); DAYNA BOWEN MATTHEW, CTR. FOR HEALTH POL'Y AT BROOKINGS, THE LAW AS HEALER: HOW PAYING FOR MEDICAL-LEGAL PARTNERSHIPS SAVES LIVES AND MONEY 20-24 (2017).

134 *See* Catherine Siyue Chen, Fernando P. Cosio, Deja Ostrowski & Dina Shek, *Developing a Pedagogy of Community Partnership Amidst COVID-19: Medical-Legal Partnership for Children in Hawai'i*, 28 CLINICAL L. REV. 107, 119 (2021).

135 Shek, *supra* note 133, at 112-13; Makhlouf, *supra* note 130, at 120–21.

136 *See* Shek, *supra* note 133, at 124-25.

137 *See, e.g.*, Makhlouf, *supra* note 130, at 120; Emily Benfer, James Bhandary-Alexander, Yael Cannon, Medha Makhlouf & Tomar Pierson-Brown, *Setting the Health Justice Agenda: Addressing Health Inequity & Injustice in the Post-pandemic Clinic*, 28 CLIN. L. REV. 45, 80-82 (2021).

138 *See* Benfer et al., *supra* note 137, at 80-82 (citing Horst W. J. Rittel & Melvin M. Webber, *Dilemmas in a General Theory of Planning*, 4 POL'Y SCIENCES 155, 160-167 (1973)).

139 *See* Benfer et al., *supra* note 137, at 51-52 (citing Horst W. J. Rittel & Melvin M. Webber, *Dilemmas in a General Theory of Planning*, 4 POL'Y SCIENCES 155, 160-167 (1973)).

140 *See* Makhlouf*, supra* note 130 at 121; *See* Girard et al., *supra* note 106, at 12.

and public health students called "Health Justice Lab: Race and Health Equity," in which students study the role of racism in medicine, public health, and law through discussions, case studies, community outreach, and advocacy work.[141]

Shek also argues that MLPs should not only name institutional racism but work to understand its local mechanisms and act to dismantle it.[142] For both criminal and civil A-MLPs, racial justice should be a stated and prevalent value guiding their work and teaching goals.[143]

B. Educating Future Lawyers, Doctors and Other Health Professionals Interprofessionally Through Antiracist Pedagogy

A-MLP law clinics should serve as a vehicle for the advancement of health and racial justice by helping future lawyers and health professionals to make the connections between these forms of justice. Students learn to identify "racism in order to address racial disparities in health and in other aspects of life which impact on health," such as education, employment, economic and housing insecurity, and incarceration.[144] They work interdisciplinarily to "understand the local mechanisms and impacts of racism," including asking the question "how is it operating here?"[145] Students consider the "messy social realities" of their clients, centering their voices and ideas, and consider how subordinated racial groups experience justice efforts.[146] This work includes investigating the role of racism in the social and structural components of health, as well as the ways in which racism itself harms health, both of which are critical components of understanding and addressing health injustice.[147]

A-MLPs should apply a health justice framework that centers racial justice interventions across their teaching and service work in both criminal and civil legal collaborations.[148] A-MLPs can aim to educate students on inequitable power formations (such as the carceral and eviction systems) and the health impacts of intersectional discrim-

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[141] L. Kate Mitchell, Maya K. Watson, Abigail Silva & Jessica L. Simpson, *An Interprofessional Antiracist Curriculum Is Paramount to Addressing Racial Health Inequities*, 50 J.L. MED. & ETHICS 109, 112-13 (2022).

[142] *See* Shek, *supra* note 133, at 131.

[143] Cannon, *supra* note 118.

[144] Shek, *supra* note 133, at 131 (citing Camara Phyllis Jones, *Confronting Institutionalized Racism*, PHYLON 7, 18-20 (2003))

[145] *Id.*

[146] *Id.* at 125-26 (citing Eric Yamamoto, *Critical Race Praxis: Race Theory and Political Lawyering Practice in Post-Civil Rights America*, 95 MICH. L. REV. 821, 828 (1997)).

[147] Makhlouf, *supra* note 129; Benfer et al., *supra* note 137, at 77.

[148] Benfer et al., *supra* note 137, at 77.

ination across both criminal and civil legal systems.[149] They can help students surface the inadequacy of the law on the books from their practice experience, the ways they can approach their work from a racial justice perspective, and the need for non-reformist reforms and abolition work to dismantle systems that cause racialized violence.[150]

Such interprofessional learning must involve exploring the role of structural racism in law and healthcare—the very professions and disciplines of A-MLP learners—as a root cause of health inequities, along with broader examination of the ways criminal and civil legal systems drive racial health disparities. In the classroom and in the field, interprofessional collaboration promotes not only cultural humility, but also "structural competency," to ensure that professionals across disciplines understand "governmental policies, residential patterns, and environmental inputs [and criminal justice system harms] outside the clinical setting that impact health," which can expand the impact of lawyers and medical providers on population health.[151]

By integrating anti-racist pedagogy into interprofessional collaboration, A-MLP learners can strengthen their understanding of racial health injustice, better reflect on their own roles in maintaining racial subordination, and work with others in their careers to address and prevent the health harms of systemic racism.[152] The interprofessional environment also encourages students to collaborate, learn, teach, and exercise new skills.[153]

This type of curricular focus also advances the goal of the American Bar Association (ABA) that every law student be educated "on bias, cross-cultural competency, and racism" at least twice, which is now required of law school curricula per ABA Standard 303.[154] For

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149 Makhlouf, *supra* note 129; Amna Akbar, *Demands For a Democratic Political Economy*, 134 HARV. L. REV. 90, 97 (2020) ("Organizers are increasingly using the heuristic of non-reformist reforms to conjure the possibility of advancing reforms that facilitate transformational change."); Amna Akbar, *Teaching Penal Abolition*, L. & POL. ECON. BLOG (July 15, 2019), https://lpeproject.org/blog/teaching-abolition/.

150 Makhlouf, *supra* note 129; Amna Akbar, *Demands For a Democratic Political Economy*, 134 HARV. L. REV. 90, 97 (2020) ("Organizers are increasingly using the heuristic of non-reformist reforms to conjure the possibility of advancing reforms that facilitate transformational change.") Amna Akbar, *Teaching Penal Abolition*, L. & POL. ECON. BLOG (July 15, 2019), https://lpeproject.org/blog/teaching-abolition/.

151 Peter S. Cahn, *How Interprofessional Collaborative Practice Can Help Dismantle Systemic Racism*, 34 J. INTERPROFESSIONAL CARE 431, 433 (2020); *see* Jonathan M. Metzl & Helena Hansen, *Structural Competency: Theorizing a New Medical Engagement With Stigma and Inequality,* 103 SOC. SCI. & MED. 126, 129-30 (2014).

152 Cahn, *supra* note 151, at 433.

153 *See* Girard et al., *supra* note 106, at 7.

154 STANDARDS & RULES OF PROC. FOR APPROVAL OF L. SCHS. § 303(c) (AM. BAR ASS'N 2022) (stating that law students should be educated on these topics at the beginning

example, the curriculum of Boston University School of Law's Health Justice Practicum contributes to this requirement, with the student cohort engaging in individual reflections and project rounds that center the role of structural racism.[155] In turn, the students view their patient/clients more holistically.[156]

In cultivating interprofessional *experiential* education in particular, both medical and legal students gain not only knowledge, but actual experience, vocabulary, and skills in addressing racism and its detrimental impacts in healthcare and legal systems.[157] Law students learn to collaborate, as well as how to work with an expert. The medical students learn not to blindly trust other doctors and to be inquisitive about the origin of health issues in their patients. The experience of working with court-involved clients and clients with health-harming civil legal needs will benefit them in their medical careers, as they will have a better understanding of the role of structural racism in driving health inequities and draw on their experience as physician advocates within a law clinic setting. Medical students come to understand the importance of legal interventions, not just medical ones. A-MLPs provide unique opportunities for students to not just learn about these important contexts, but to put this knowledge into practice early in their careers.[158]

Early exposure to these issues gives aspiring attorneys and health professionals the tools and skills to identify and address systemic causes of racial health disparities in their future work.[159] Future doctors and other health professionals can grow more confident in their own abilities to advocate for their patients through a racial justice lens, even without legal help, and can learn to identify when a lawyer is critical to advancing their patients' needs.[160]

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of their legal education and at least one additional time before graduation); *see also* Danielle Pelfrey Duryea, Peggy Maisel & Kelley Saia, *Un-Erasing Race in a Medical-Legal Partnership: Antiracist Health Justice Advocacy By Design,* 70 WASH. U. J.L. & POL'Y 97, 117 n.67 (2023).

155 Duryea et al., *supra* note 154, at 110-11.

156 *Id.* at 110-11(noting that student-advocate teams included Black-led community organizations and Black elected officials, even if not focused on health issues, in a stakeholder and power map and that other teams proposed a requirement for licensed mandated reporters and family regulation agency staff to take classes to combat implicit bias).

157 *See* Girard et al., *supra* note 106, at 8.

158 *See* L. Kate Mitchell, L. Kate Mitchell, Maya K. Watson, Abigail Silva & Jessica L. Simpson, *An Interprofessional Antiracist Curriculum Is Paramount to Addressing Racial Health Inequities*, 50 J.L. MED. & ETHICS 109, 112-13 (2022).

159 Makhlouf, *supra* note 129.

160 *See* Dina M. Shek & Alicia G. Turlington, *Building a Patient-Centered Medical-Legal Home in Hawaii's Kalihi Valley*, 78 HAW. J. MED. & PUB. HEALTH 55, 56 (2019).

C. Grounding A-MLP Work in CRT and Other Critical Legal Studies

A-MLPs should also develop racial justice strategies across their pedagogy and advocacy based on principles of critical race theory (CRT).[161] Makhlouf argues for incorporation of a CRT framework in MLPs to educate legal and medical professionals about structural racism and its effects, intersectional discrimination, and the insufficiency of our laws in addressing racial health inequity, as well as to facilitate interdisciplinary collaboration and education.[162] Using CRT frameworks in A-MLP teaching can also help pre-professional students understand these concepts, as well as implicit biases in the legal and health professions they are entering.[163]

Myriad approaches from CRT can be used by A-MLPs to advance health and racial justice. Some of the CRT approaches for which health justice and public health scholars have advocated include counternarratives, centering the voices and stories of people traditionally relegated to the margins, practicing race consciousness, understanding intersectionality, and praxis.[164]

Counternarratives are stories which "disrupt. . .complacency and engage the conscience" thereby "help[ing] policymakers understand why the status quo is unacceptable and what impactful reform would entail."[165] A-MLPs can help students learn storytelling skills and thus deploy counternarratives in their advocacy, such as sharing stories with judges and policymakers that serve to disrupt dominant narratives, including individualistic narratives that blame people of color for the health inequities they experience. Centering in the margins similarly involves approaches that A-MLPs can use in their teaching and curricular choices, and advocacy both in individual civil and criminal cases and for policy change, "ensur[ing] that the perspectives of historically and currently marginalized groups are 'the central axis around which discourse . . . evolves.'"[166]

Race conscious approaches require exploring racialized social contexts, identifying salient aspects of contemporary racism and

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161 Benfer et al., *supra* note 137, at 77.

162 *See* Makhlouf, *supra* note 129.

163 *See* Girard et al., *supra* note 106, at 12.

164 Benfer et al., *supra* note 137, at 77; Girard et al., *supra* note 106, at 12.; *see also* Dina Shek, supra note 133, at 126 (citing Eric Yamamoto, *Critical Race Praxis: Race Theory and Political Lawyering Practice in Post-Civil Rights America*, 95 MICH. L. REV. 821, 830 (1997)); Chandra L. Ford & Collins O. Airhihenbuwa, *Critical Race Theory, Race Equity, and Public Health: Toward Antiracism Praxis*, 100 AM. J. PUB. HEALTH S30, S31-34 (2010).

165 Cannon & Tuchinda, *supra* note 49 at 778 (citing Richard Delgado, *Storytelling for Oppositionists and Others: A Plea for Narrative*, 87 MICH. L. REV. 2411, 2438, 2415 (1989)).

166 *Id.* at 779.

racialized power imbalances, and fighting against the notion of a colorblind society.[167] For example, in seminar in the criminal clinic, offering a class about how the racism and poverty clients have endured can cause trauma responses is an approach that embodies the CRT principle of intersectionality. Exploring intersectionality in this context helps future lawyers and physicians understand that a "person may experience multiple marginalizations. . .and the distinct experiences of a multiply marginalized person, including their health, cannot be fully understood and addressed by looking at and treating each form of marginalization separately."[168]

CRT approaches also include the centering by A-MLPs of the role of racism across both civil and criminal legal systems and active work by A-MLPs to keep patients, including those with intersectional identities, out of systems that inflict racialized harm (such as the criminal justice system, eviction courts, the school-to-prison pipeline and family regulation system), to reduce the racialized harm that those systems exact, and to dismantle those systems.[169] For example, a recent proposal for Boston University A-MLP to support patients of a Massachusetts health center providing substance abuse treatment to pregnant individuals emphasizes the need for an anti-racist design reflecting CRT principles like race consciousness and intersectionality.[170] The interdisciplinary seminar curriculum centers "anti-Black racism and misogyny in the family regulation, drug policy, health care, and related systems, and offered a health justice frame for the students' work."[171] It also proposes comprehensive legislative and policy proposals that "drew more expansive connections among forms of racism, misogyny, and stigma."[172]

A-MLPs should also deploy the CRT principle of praxis, which is "the iterative process of deploying knowledge derived through study and experience to take direct action"[173] that requires "tak[ing] account of how subordinated racial groups experience justice efforts"[174]

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[167] Chandra L. Ford & Collins O. Airhihenbuwa, *Critical Race Theory, Race Equity, and Public Health: Toward Antiracism Praxis*, 100 AM. J. PUB. HEALTH S30, S31 (2010).

[168] Cannon & Tuchinda, *supra* note 49 at 778 (citing Kimberlé Crenshaw, *Mapping the Margins: Intersectionality, Identity Politics, and Violence Against Women of Color*, 43 STAN. L. REV. 1241 (1991)).

[169] Cannon, *supra* note 14 at 83 (2023) (citing Colleen F. Shanahan, Jessica K. Steinberg, Alyx Mark & Anna E. Carpenter, *The Institutional Mismatch of State Civil Courts*, 122 COLUM. L. REV. 1471, 1475-76 (2022)).

[170] Duryea et al., *supra* note 154, at 98.

[171] *Id.* at 109.

[172] *Id.* at 111.

[173] *See* Benfer et al., *supra* note 137, at 77 (citing Chandra L. Ford & Collins O. Airhihenbuwa, *Critical Race Theory, Race Equity, and Public Health: Toward Antiracism Praxis*, 100 AM. J. PUB. HEALTH S31, tbl. 1 (2010)).

[174] *See* Shek, *supra* note 133, at 126 (citing Eric Yamamoto, *Critical Race Praxis: Race*

and listening and acknowledging the experiences of members of marginalized groups.[175] For example, MLP Hawai'i seeks out and listens to the "race stories" of their clients, attends community meetings to understand the needs and goals of community members, and contributes to grassroots efforts.[176]

D. Patients-to-Policy Advocacy

As described above, advocacy by A-MLPs in pursuit of health and racial justice includes enforcing and implementing existing laws that often go under-enforced or under-implemented for people from minoritized and marginalized communities, such as housing codes that require that tenants are provided with humane and habitable conditions and compassionate release statutes, resulting in health-harming legal needs and health inequities.[177] A-MLP advocacy can also advance racial justice by identifying patterns and gaps in extant laws and locating opportunities to reform law and policy, which is known as a "patients-to-policy" approach.[178] Students can work towards the dismantling of structural racism by listening to patient-clients to identify harmful policies and practices and then supporting and collaborating with community-led efforts to push for policy change.[179] This frame was used by the Health Justice Alliance Law Clinic in the aforementioned advocacy by law students, medical students, physicians, and clients to amend laws to promote prevention of lead exposure among children, which disproportionately affects Black children.[180]

Students gain a lot from learning about and engaging in systemic advocacy with racial justice aims. For example, recognizing that laws and policies are often at the root of disproportionate harm inflicted on communities of color, medical students are increasingly embracing advocacy at the local and national levels and looking to their academic institutions to provide the training they need to be effective advo-

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Theory and Political Lawyering Practice in Post-Civil Rights America, 95 MICH. L. REV. 821, 881 (1997)).

175 *Id.* at 126 (citing Eric Yamamoto, *Critical Race Praxis: Race Theory and Political Lawyering Practice in Post-Civil Rights America*, 95 MICH. L. REV. 821, 830 (1997)).

176 *Id.* at 127.

177 *See generally* Cannon, *supra* note 19 (2020).

178 *See* Shek, *supra* note 133, at 111-12; Makhlouf, *supra* note 130, at 119; Cannon, *supra* note 118 (2021).

179 *See* Shek, *supra* note 133, at 111-27; Cannon, *supra* note 14 (2023), at 79 (citing *Story Series Features Teams that Took SDOH Problem-Solving from Patients-to-Policy*, NAT'L CTR. FOR MED.-LEGAL P'SHIP (May 2, 2018), https://perma.cc/VE4F-RXHF.).

180 Deniz Yeter et al., *Disparity in Risk Factor Severity for Early Childhood Blood Lead among Predominantly African-American Black Children*: *The 1999 to 2010 US NHANES*, 17(5) INT. J. ENV'T. RSCH. PUB. HEALTH 1 (2020).

cates.[181] A-MLPs can play a role in providing this type of training and opportunities for activism in pursuit of racial justice.

E. Building Client and Community Power

A-MLPs should advance racial justice by building the power of the clients at the center of their work in order to avoid maintaining the destructive systems which necessitated the involvement of the A-MLP.[182] Medical-legal teams can give clients health education and the legal knowledge and tools necessary for clients to assert their own rights in the future when they encounter criminal and civil systems, such as during police encounters or landlord-tenant disputes.[183] Helping equip clients with tools for future problem-solving and self-advocacy can promote legal consciousness and build power in ways that advance racial justice.[184] These efforts provide valuable experience to students that can change the way they practice and provide tangible benefits to clients.[185]

MLPs increasingly work to build the collective power of affected communities by collaborating with clients and grassroots organizations to serve as resource allies and ensure that affected individuals drive health justice agendas.[186] For example, the HJA Law Clinic team prepared a client to testify and tell her story of the lead poisoning experienced by her children in order to advocate for systemic justice.[187] This approach has been "prioritized by the Health Justice Alliance Law Clinic to elevate clients' power in pursuit of transformative change"[188] by giving them opportunities to share their stories and ideas for reforms directly with policymakers and opportunities to get involved with grassroots organizations working towards racial justice. Similarly, Boston University School of Law's Health Justice Practicum partners with Black-led organizations to engage in stakeholder and power mapping and to design broader policy solutions and goals to

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[181] *See* STUDENT NAT'L MED. ASS'N., RACISM IS A PUBLIC HEALTH ISSUE 19 (2020), https://cdn.ymaws.com/snma.org/resource/resmgr/hlpa/report_racism.pdf.

[182] *See* Shek, *supra* note 133, at 122; Benfer et al., *supra* note 137, at 73.

[183] *See* Shek, *supra* note 133, at 122; Benfer et al., *supra* note 137, at 73.

[184] *See* Catherine Siyue Chen et al., *supra* note 134, at 117; Shek, *supra* note 133, at 127; Dina M. Shek & Alicia G. Turlington, *Building a Patient-Centered Medical-Legal Home in Hawaii's Kalihi Valley*, 78 HAW. J. MED. PUB. HEALTH 55, 57-58 (2019); *see also* Cannon, *supra* note 14 (2023), at 78.

[185] *See* Girard et al., *supra* note 106, at 8; Cannon, *supra* note 118 (2021) (describing multiple forms of successful advocacy conducted by students at the Health Justice Alliance Clinic); Benfer et al., *supra* note 137, at 63.

[186] Cannon, *supra* note 14 (2023), at 80.

[187] Cannon, *supra* note 118 (2021).

[188] Cannon, *supra* note 14 (2023), at 79.

advance health justice.[189]

F. Cross-System Advocacy

For years, the legal and medical professions and the academy have siloed criminal and civil legal systems from one another, with A-MLPs primarily focused on civil systems. But the reality is that many of the people ensnared in one legal system will be ensnared in the other.[190] Individuals in both systems suffer from ill-health long blamed on independent choices rather than the structural inequities forced upon them. Many of these systems are deeply racially unjust. In light of the country's history of enslavement, Jim Crow, and other instances of legalized subjugation that have been propped up by our legal systems, preparing future lawyers and doctors to address these injustices with every available tool is imperative for the legal profession.

Though the legal field views the civil and criminal systems to be distinct,[191] the many people of color embroiled in these two systems and cycles know based on their own experiences that these systems have fluid boundaries.[192] Access to justice legal scholar Lauren Sudeall argues that the siloed approach suffers from practical problems, as it does not recognize the lived experiences of the many individuals in both systems.[193] And people of color are disproportionately represented across both systems. The same people (or their family members, friends, or neighbors) might be clients of a criminal defense law clinic or a public defender's office *and* a law school civil advocacy clinic or civil legal aid organization. Structural racism and its resulting impoverishment of people of color have ensured that these are the same people, just in different courtrooms.

The distinction between civil and criminal legal systems fails to acknowledge the interaction between the two systems and how legal issues arise in people's lives,[194] and the extent to which health, mental

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189 Duryea et al., *supra* note 154, at 110-11 (noting that student-advocate teams included Black-led community organizations and Black elected officials, even if not focused on health issues, in a stakeholder and power map and that other teams proposed a requirement for licensed mandated reporters and family regulation agency staff to take classes combating implicit bias).

190 *See generally* MICHELLE ALEXANDER, THE NEW JIM CROW: MASS INCARCERATION IN THE AGE OF COLORBLINDNESS (The New Press 2010).

191 *See* Lauren Sudeall, *Rethinking the Civil-Criminal Distinction*, *in* TRANSFORMING CRIMINAL JUSTICE: AN EVIDENCE-BASED AGENDA FOR REFORM 268, 268 (NYU Press 2022).

192 *See* Lauren Sudeall, *Integrating the Access to Justice Movement*, 87 FORDHAM L. REV. 172, 174 (2019); Sara Sternberg Greene, *Race, Class, and Access to Civil Justice*, 101 IOWA L. REV. 1263, 1289 (2016); *see also* Sudeall, *supra* note 191 (2022), at 275.

193 *See* Sudeall, *supra* note 191 (2022), at 270.

194 *See Id*.

health, and well-being are harmed by inter-connected entanglement across systems. For example, participation in the civil justice system can lead to incarceration and its resulting health harms when a parent fails to pay court-ordered child support.[195] Or an individual may experience homelessness after being evicted, an outcome disproportionately wrought on women of color, who experience the highest rates of evictions.[196] While the person may have been evicted through civil court proceedings, they might be prosecuted for trespassing into a warm place to sleep or panhandling for money to buy food.[197] The person's eviction, homelessness, food insecurity, and criminalization all have grave consequences for their health and for people of color, all of these circumstances drive health inequities.

On the other side, for example, involvement in the criminal legal system can lead to civil penalties like deportation or eviction from public housing.[198] Yet, even the penalties themselves are not neatly separate to those facing them; while a court might find a penalty to be civil and non-punitive, many defendants may experience that penalty as deeply punitive and harmful, such as a deportation or the loss of custody that can occur when a parent is incarcerated.[199] Deportation can result in significant stress, trauma, and poor health and mental health for people and their family members,[200] as can parental incarceration.[201]

And of course a single matter might lead to both civil and criminal cases with health and racial justice implications. For example, a survivor or a person accused of domestic violence may be involved in civil and criminal matters resulting from the same instance of violence;

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195 *See* Colleen F. Shanahan, Jessica K. Steinberg, Alyx Mark & Anna E. Carpenter, *The Institutional Mismatch of State Civil Courts*, 122 COLUM. L. REV. 1471, 1475 (2022); *see also* Elizabeth D. Katz, *Criminal Law in a Civil Guise: The Evolution of Family Courts and Support Laws*, 86 U. CHI. L. REV. 1241, 1252 (2019) ("[A] substantial component of family law has long been criminal law.").

196 *See* Kathryn A. Sabbeth, *Housing Defense as the New* Gideon, 41 HARV. J.L. & GENDER 55, 67 (2018) (citing MATTHEW DESMOND, EVICTED: POVERTY AND PROFIT IN THE AMERICAN CITY 98 (2016)); Tonya L. Brito et al., *Racial Capitalism in the Civil Courts*, 122 COLUM. L. REV. 1243, 1246 (2022).

197 *See* Sabbeth, supra note 196, at 67.

198 *See* Sudeall, *supra* note 191 (2022), at 270 ; Lauren Sudeall, supra note 192 (2019), at 174; Kathryn A. Sabbeth, *The Prioritization of Criminal Over Civil Counsel and the Discounted Danger of Private Power*, 42 FLA. STATE U. L. REV. 889, 913 (2015).

199 *See* Sudeall, *supra* note 191 (2022), at 271-72.

200 *See* Samantha Aritga & Barbara Lyons, *Family Consequences of Detention/Deportation: Effects on Finances, Health, and Well-Being*, KAISER FAMILY FOUNDATION (Sept. 18, 2018) https://www.kff.org/racial-equity-and-health-policy/issue-brief/family-consequences-of-detention-deportation-effects-on-finances-health-and-well-being/.

201 *See* Eric Martin, *Hidden Consequences: The Impact of Incarceration on Dependent Children*, NAT'L INST. OF JUST. (March 1, 2017), https://nij.ojp.gov/topics/articles/hidden-consequences-impact-incarceration-dependent-children.

these matters could include a criminal case for battery, a civil protective order, a civil case for custody, and more, entangling people in systems where people of color are over-represented, with health consequences.[202]

To address the issue of strictly distinct systems, Sudeall suggests early engagement with law students, where they might learn to examine clients and their problems holistically.[203] A-MLPs provide an important vehicle for this type of education and have the added benefit of training students and providers from health professions to also think holistically about the needs of clients. Future lawyers and health professionals can work across civil and legal systems through integrated advocacy to advance racial justice.

Conclusion

The Academic Medical-Legal Partnership model provides an important opportunity to advance racial justice because it reaches attorneys, physicians, and other health professionals at formative stages of their careers. Before they have fully developed professional identities, habits, skills, values, and knowledge, they can learn to identify and critically examine the civil and criminal injustices and connected health inequities that result from structural racism—and have the tools and experience to address them. They can learn how and why both evictions and incarceration, for example, disproportionately impact Black people and other people of color, to the detriment of their health and well-being, and can learn how to collaborate to prevent and disrupt those individual outcomes, as well as reform the systems that create such disparities.

Both law and health professions students learn to see clients/patients as people, not cases or medical diagnoses, which is equally important for individuals experiencing civil and criminal legal needs. Students learn to think about how various legal needs are intertwined both across systems and with health, social service, and other needs. This type of client-centered and structural thinking in collaborative problem identification, analysis, and advocacy can serve to advance racial justice, as the needs of clients/patients across civil and criminal legal systems both implicate structural determinants of health and health inequities driven by structural racism that require intentionally antiracist approaches. Interprofessional experiential education through both civil and criminal A-MLPs can prepare future lawyers, physicians, and other health professionals to advance racial and health

[202] Sudeall, *supra* note 191 (2022), at 273.
[203] *See Id.* at 286-87.

justice throughout their careers.