COLUMBIA
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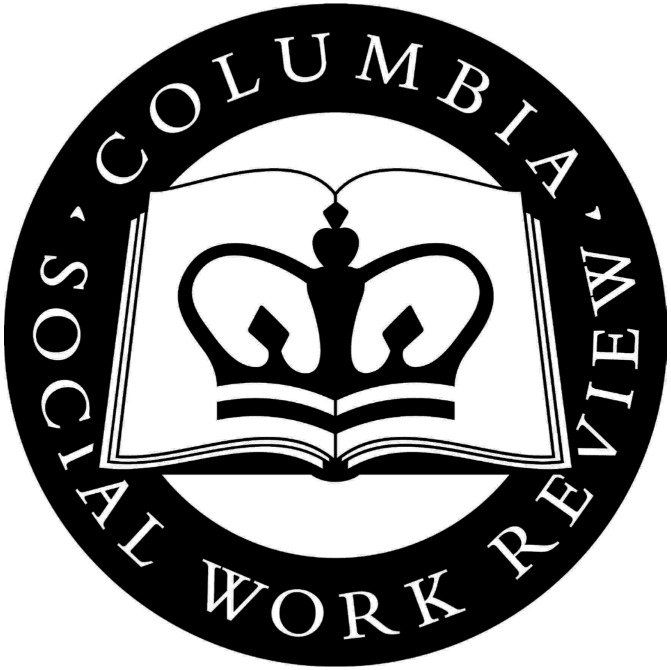
COLUMBIA SOCIAL WORK REVIEW

The mission of the *Columbia Social Work Review* is to provide a forum for the exchange of innovative ideas that integrate social work practice, education, research, and theory from the perspective of social work students. Founded by students at Columbia University School of Social Work in 2003 as the *Columbia University Journal of Student Social Work*, this academic journal provides an opportunity for students and scholars in the field of social work to share their unique experiences and perspectives with fellow students, faculty, and the larger social work community.



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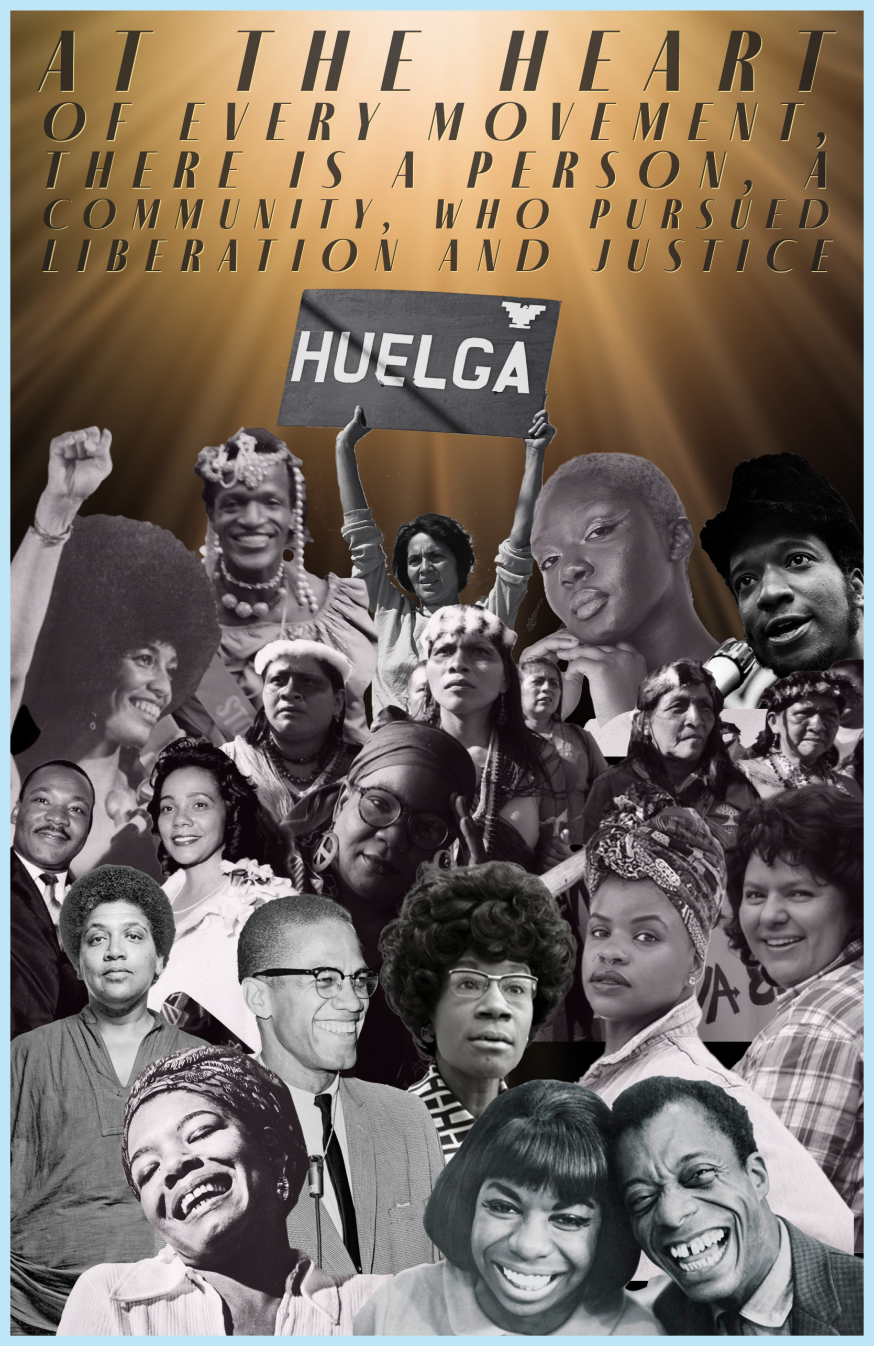

JOURNAL STATEMENT

The *Columbia Social Work Review (CSWR)* proudly seeks to afford voices who are ordinarily overlooked in academic settings the opportunity to be published. Our authors include students and alumni from underrepresented groups or regions, with diverse viewpoints, and those early in their social work career seeking to make a contribution to the field. Our journal is committed to social equity and to the project of dismantling systems of power, race, oppression, and privilege by including pieces that discuss a variety of topics through a social justice lens, edited by a staff of students who represent different identities and lived experiences.

This last year has seen heightened racial tension with displays of anti-Black racism and increases in violence against Asian and Pacific Islander communities, as well as the pandemic's ongoing magnification of systemic inequities, such as structural racism, ableism, and (cis)sexism throughout the United States and beyond. We at the *Columbia Social Work Review* acknowledge that the cultures within academia and scholarly journals also contribute to upholding systems of oppression. Additionally, *CSWR* recognizes that we often discuss the pervasiveness of these systems after traumatic events have taken place. By collecting the diverse research articles included in this edition, our journal is actively working towards highlighting harms that have not yet reached the collective consciousness.

As always, we have more work to do.

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ACKNOWLEDGMENTS

We would like to extend our deepest and most sincere thanks to our faculty advisor, Dr. Susan Witte. Her unwavering support has allowed us to expand the journal in size and in impact. Special thanks to Writing Center Director Adam Pelligrini for sharing his expertise with our editorial board. Thank you Stacy Kass and Jennifer March for providing vital fundraising support. We welcome Dean Melissa Begg to the Advisory Board and would like to thank the rest of our Advisory Board as well for their feedback and guidance. Thank you to Christian Marie Marquardt Mendoza Acosta for enhancing the journal with her beautiful artwork. Thank you to Savannah Brogan for her contribution to layout and design and assisting us in reimaging this year's volume. Thank you to the inaugural Prize Selection Committee for your thoughtful deliberation and selection. Thank you to our talented and passionate authors for your trust and collaboration. Finally, our utmost gratitude to our incredible editorial board for their dedication to the work and social justice.

GAËLLE BOTTEX AND
KATHARINA LEMMERZ
Editors in Chief, 2020-2021

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PUNCTUATION NOTE

In line with prevailing social justice movements seeking to dismantle and disrupt white supremacy, Volume 19 of the *Columbia Social Work Review* will not capitalize the word “white” when referring to a race, but will capitalize the first letters of other races and ethnicities (Black, Hispanic-Latinx, Asian (American), African (American), etc.). While no standard capitalization of white currently exists, the journal’s decision affirms the argument that “white” does not “represent a shared culture or history the way that Black does” (Bauder, 2020, para.7) and recognizes that some white supremacist groups capitalize the word (Bauder, 2020).

RESHA T. SWANSON

Author of "Still Fighting: The Relationship
Between Contemporary Preemption in the South and
the Continued Struggle for Black Worker Rights"

EDITORS' INTRODUCTION

Over the past year spent producing this volume, millions of people have been impacted by the COVID-19 pandemic, political turmoil, and racially motivated violence. Despite all we have endured, our editorial board persevered by not only forming a supportive community, but creating a journal that stands with those impacted.

It is with profound pride that we introduce the 19th Volume of the *Columbia Social Work Review*. These articles amplify the ongoing work of highlighting and dismantling systems of oppression through clinical frameworks, policy analyses, and community engagement. "The *Testimonios* of System-Impacted Daughters of Color on Healing from Parental Incarceration" by Angie Belen Monreal provides original research on the potential impact counter-storytelling can have as a healing tool for daughters of incarcerated parents. In "The Overdiagnosis of Bipolar Disorder Within Marginalized Communities: A Call to Action", Paul Doyen identifies the origins of the overdiagnosis of bipolar disorder and what is needed to remedy this problem. "Unique Causes And Manifestations Of Eating Disorders Within Transgender Populations" by Sula Malina unpacks the research surrounding eating disorders within transgender populations and centers the role of social work within their recommendation. In "Time Doesn't Heal All Wounds: A Call to End Mandated Reporting Laws", G Inguanta and Catharine Sciolla explore the historical oppression perpetuated by the child welfare systems and what a world without reporting would look like.

"Violence Against Indigenous Women in the United States: A Policy Analysis" by Annie Benjamin and Elizabeth Gillette provides an evaluation of the shortcomings of legislation at preventing violence against Indigenous women followed by recommendations for change. "Still Fighting:The Relationship Between Contemporary Preemption in the South and the Continued Struggle for Black Worker Rights" by Resha T. Swanson examines the oppression of Black workers by connecting historical origins of preemption to ongoing, twenty-first century legislation."Mind the Gap: Addressing Childcare Inequalities for Children and Caregivers" by Juliana Pinto McKeen explores the ways in which childcare in the United States is inequitable and has impeded access to early childhood education. "Peer Support as a Tool for Community Care: 'Nothing About Us, Without Us'" by Shinjini Bakshi delves into the ways anti-carceral social work can utilize both formal and informal peer support in the mental health movement.

Finally, we present this year's winner of the *CSWR* Paper Prize, generously funded by donations from alumni and friends of the Review. The Prize is awarded to an exceptional paper submission addressing an issue of power, race, oppression and privilege and proposing an innovative intervention, theory or approach to address the issue identified. This year's winner is Tanesha Goldwire Tutt. Tanesha's paper, "Healthcare Policy: Federally Mandated Insurance Coverage for Infertility Treatment", emphasizes the need for federally mandated insurance coverage for infertility and the roles social workers can play in advocating for this movement.

WE ARE COMMITTED TO SOCIAL EQUITY AND TO THE PROJECT OF DISMANTLING SYSTEMS OF OPPRESSION.

As reflected in our Journal Statement, we are committed to social equity and to the project of dismantling systems of oppression. We are confident that the 19th Volume of the *Columbia Social Work Review* includes a myriad of topics pertaining to social justice on the micro, mezzo, and macro levels.

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Healthcare Policy: Federally Mandated Insurance Coverage for Infertility Treatment

TANESHA GOLDWIRE TUTT
CSWR PAPER PRIZE RECIPIENT
SHE/HER

Approximately 15% of couples in the United States (U.S.) suffer from infertility. Existing infertility treatments and alternate paths to parenthood, such as adoption, are available but financially inaccessible and require self-payment. Although organizations such as the American Medical Association (AMA) and World Health Organization (WHO) classify infertility as a disease, the U.S. has not federally mandated insurance coverage for infertility. Currently, only 15 states require insurance companies to offer some type of fertility benefit and these requirements vary across states.

This paper discusses the need to federally mandate insurance coverage for infertility in the U.S. Infertility not only causes devastating outcomes for individual families, but affects nearly all demographics across the world. However, national legislation on infertility coverage continues to fail the many couples who suffer from this condition. The paper concludes with implications for social work practice and recommends ways social workers can support this policy movement. Social workers have an ethical duty not only to address clients' mental and emotional needs, but also to be at the frontlines of policy and to advocate for federal insurance coverage for clients who desperately want to realize their dream of conceiving a child.

Keywords: fertility, infertility, insurance coverage, insurance, in vitro fertilization (IVF)

POSITIONALITY STATEMENT

I write from the positionality of an individual who has had personal experience with infertility. As a cisgender woman, I know what it is to face the reality that conceiving a child is a privilege, and that not everyone will know the joy of pregnancy through heterosexual intercouse. I know what it is to grieve over the unmet expectation of bearing a child. The mental, emotional, physical, and financial strain my husband and I experienced seemed unreal, unfair, and unfathomable. The level of bias, discrimination, and sometimes ignorance we encountered while trying to navigate our infertility was unbelievable.

I also write from a positionality of privilege as a cisgender woman in a heterosexual relationship. Our diagnosis forced me, my husband, and those in our circle to confront our own ignorance. We were guilty of "meddling" in others' fertility, failing to consider that a person or couple may not have had a choice in either delaying or forgoing starting a family. We also had to confront our own bias, as we were conditioned to believe that only women could suffer from infertility. Feeding into gender binary viewpoints, I dismissed the idea that LGBGTQIA+ couples and individuals also face the pain and demoralization that infertility can cause.

Finally, I write from the positionality of a minority. While I speak as a person of privilege in terms of my sexual and gender identity as a heterosexual cisgender woman, I am a Black woman married to a Black man. I understand what it is to be stigmatized and marginalized when trying to access infertility treatment and financial support. I witnessed firsthand the privilege that exists for white women, white men, and white couples who are afforded opportunities and access to fertility treatments that are not available to those of other races and ethnicities. I realized that social constructs narrowly define who can be impacted by infertility, who is deserving of support, and who should have access to various types of treatments, coverage, and care.

This article reflects a gender binary point of view and focuses on those who are cisgender, and in that way it is indicative of the lack

of research that exists on other populations that may be dealing with infertility. As a person of fertility privilege and disenfranchisement, I can identify with those in both categories. The experiences of being dismissed, unheard, and unrecognized fueled my passion to write this article, in hopes that it would generate awareness of infertility, its effects, and the need to advocate for changes in laws and policies that marginalize those who are suffering with the disease.

HEALTHCARE POLICY: FEDERALLY MANDATED INSURANCE COVERAGE FOR INFERTILITY TREATMENT

In 2020, UCLA Health reported that approximately 15% of couples will struggle with infertility (UCLA Health, 2020). According to MedlinePlus (n.d.), infertility is the inability to become pregnant after 12 months of trying to conceive and includes miscarriages and stillbirths. Despite the WHO and the AMA classifying infertility as a disease, there is no federally mandated insurance coverage for infertility treatment (Insogna & Ginsburg, 2018; Strauss, 2018).

For many couples around the world, having a baby is a critical step to building a family. For both the person trying to conceive and their partner, a diagnosis of infertility can lead to many challenges such as anger, depression, sexual dysfunction, divorce, and social isolation (Deka & Sarma, 2010). Given the prevalence of infertility, its underrecognized status as a disease that warrants coverage, and the high costs people pay to exercise their right to conceive a child, federally mandated insurance policies are a vital but missing component of our nation's healthcare landscape.

THE SOCIAL PROBLEM

In the U.S., at least one in eight couples will experience infertility (RESOLVE, 2019). Among married couples, about 7% of women and 16% of men, ranging in age from 15-44, are classified as infertile (Centers for Disease Control [CDC], 2016; Chandra et al,, 2013). Infertility is typically viewed as a female condition, but in approximately 40% to 50% of infertility cases, the male is the factor leading to infertility

(Kumar & Singh, 2015). Infertility can be treated with medication, surgery, intrauterine insemination (IUI), or assisted reproductive technologies (ARTs) such as in vitro fertilization (IVF). These fertility treatments involve extracting eggs and embryos from a female and either combining them with sperm in a laboratory and reinserting into the body, or donating them to another woman (CDC, 2019). Each treatment comes with its own costs, risks, and rates of success.

DISPROPORTIONATE IMPACTS ON MARGINALIZED POPULATIONS

The medical definition of infertility is the "inability of couples to conceive after at least 1 year of having sex without using birth control methods" (U.S. National Library of Medicine, 2019, para 1). This definition limits those capaable of experiencing infertility to heterosexual couples that have intercourse. It assumes that only men and women try to have children, and also focuses on women's bodies instead of men's. However, men and same sex-couples need support with infertility, too. The current definition of infertility fails to address the inclusiveness needed to ensure all populations can receive equal and adequate access to support and care for infertility and leaves room for interpretation of who does and does not deserve access to care.

Much of the research, advocacy, and support for infertility focuses on white, heterosexual women (Shreffler et al., 2017). Although African American, Chinese, and Latine couples have higher rates of infertility than white couples, they are less likely to seek treatment (Inhorn & Patrizio, 2018; Insogna & Ginsbury, 2019). According to a study published in Health Psychology, "heterosexual white women are twice as likely as racial or sexual minority women to obtain medical help to get pregnant" (Blanchfield & Patterson, 2015, p. 575). The study further explains that a cause for this lack of pursuing treatment a lack of health insurance. Moreover, as of 2018, Blacks are still 1.5 times as likely as whites to be uninsured (Ariga et al., 2020).

Blanchfield and Patterson (2015) found that in studies conducted in 2002 and again from 2006 to 2010, 13% of white heterosexual women received assisted reproductive medical support, while only 7% of minority heterosexual women and white sexual minority women received support. Furthermore, only 1% of women who identified as both racial and sexual minorities were found to have received such support. Men were not included in the study, speaking to the gap in the literature on infertility in men. Feinberg and colleagues (2005) found that when African Americans had access to healthcare through partial insurance, there was a 400% increase in their utilization of ARTs. Yet even with access, minority patients had poorer health outcomes than white patients, including higher spontaneous abortions, lower clinical pregnancy rates, and lower live births (Insogna & Ginsbury, 2019). Thus, even with lower successful outcome rates, minorities clearly benefit from having insurance to cover infertility treatments.

BARRIERS TO ACCESSING TREATMENT

In addition to its widespread impact and disproportionate effects on marginalized groups, infertility warrants insurance coverage. However, inconsistent nationwide coverage policies have created major cost burdens for individuals. In 1948, the United Nations Universal Declaration of Human Rights stated that every person has a right to start a family, and in 2015, the American Society of Reproductive Medicine (ASRM) Ethics Committee stated that "reproduction is a fundamental interest and human right" (2015). However, U.S. legislation has failed to recognize that infertility is a disease that denies people the basic human right of conceiving a child. Additionally, while the WHO and AMA classify infertility as a disease, many insurance companies in the U.S. do not cover infertility and erroneously view infertility treatment as experimental medicine (Strauss, 2018). This label neglects the substantial body of research highlighting that procedures to address infertility, such as egg freezing, are no longer experimental and ARTs, such as IVF, have increased in success with as many as 8 million babies being born through IVF in 2018 (Dunne & Roberts, 2016; Strauss, 2018).

Without federal assistance, individual states bear the responsibility to determine how to regulate infertility coverage (American Society of Reproductive Medicine [ASRM] Ethics Committee, 2015, para 5; National Conference of State Legislature [NCSL], 2019; Universal Declaration of Human Rights, 1948). Currently, 19 states have infertility coverage laws that require insurance companies to either cover or offer infertility treatments as part of the policy (RESOLVE, 2020; NCSL, 2019) (see Table 1). Of those 19 states, 13 have comprehensive coverage for costs associated with IVF, and 10 have fertility preservation laws (RESOLVE, 2020) (see Table 1). However, coverage may not exist for other ART treatments and associated medications (Insogna & Ginsburg, 2018).

Four states (Georgia, Michigan, Minnesota, and New Mexico) offer one Medicaid plan to diagnose infertility, but do not mandate any level of coverage for infertility treatment (Weigel et al., 2020.) Of the states listed in Table 1, Massachusetts, New Hampshire, and New York offer this same benefit, but New York is the only state that requires Medicaid coverage to treat infertility (Weigel et al., 2020). Thus, most individuals with government insurance (state or federal) have no coverage for infertility treatments and are given no choice but to personally cover all fees associated with any ARTs (RESOLVE, 2018).

White, McQuillan, and Greil (2006) found that many physicians may hold biases about who should and should not receive infertility treatment. Without federally mandated infertility coverage, states and providers can personally define infertility and determine who receives treatment (ASRM Ethics Committee, 2015). Giving physicians power to determine who receives treatments creates an indirect and subtle--but deeply harmful--form of ethnic cleansing. Consequently, the medical field risks prioritizing communities with privilege in the provision of access. This system enables racism, ableism, transphobia, and many other forms of oppression to influence decisions of who can conceive. The subjective selection of those receiving infertility treatment promotes privilege and creates a system in which those from specific racial, ethnic, gender, and socioeconomic communities are denied access to insurance coverage and medical procedures that are critical to being able to have a baby.

TABLE 1. STATES WITH INFERTILITY INSURANCE BENEFITS

States	States with infertility insurance laws	States with IVF insurance laws	States with fertility preservation laws
Arkansas	x	x	
California	x		x
Colorado	x	x	x
Connecticut	x	x	x
Delaware	x	x	x
Hawaii	x	x	
Illinois	x	x	x
Louisiana	x		
Maryland	x	x	x
Massachusetts	x	x	
Montana	x		
New Hampshire	x	x	x
New Jersey	x	x	x
New York	x	x	x
Ohio	x		
Rhode Island	x	x	x
Texas	x		
Utah	x	x	
West Virginia	x		

From “Infertility coverage by state,” by RESOLVE, 2020

(https://resolve.org/what-are-my-options/insurance-coverage/infertility-coverage-state/)

Without consistent coverage, the costs of treatment far exceed what many couples can afford. In 2018, the average cost for infertility treatments, such as IVF, was $12,000, but some couples paid over $22,000 for one IVF cycle, depending on the types of medication needed to prepare for the treatment (Leonhardt, 2019; Strauss, 2018). In engaging in IVF, 71% of women who completed an IVF cycle were not covered by insurance (Leonhardt, 2019). Many couples spend the money fully aware that an unsuccessful fertilization could mean a loss of $12,000 and potential cost an additional $12,000 to try again. According to a 2017 article by Robert Kiltzman, the cost of a successful delivery from IVF in California was $112,799, and the cost of other paths to parenthood, such as adoption, can cost around $30,000 minimum. These are out-of-pocket funds that the average person likely does not have. The cost to treat infertility, coupled with a lack of insurance coverage for this disease, leaves many couples either struggling to fund treatment or giving up on having a baby altogether.

THE SOCIAL POLICY RESPONSE

Although there are states that do require some type of infertility insurance coverage, the Federal Employee Retirement Income Security Act exempts companies who engage in self-insurance (i.e., the companies pay medical claims themselves) from having to comply with state mandates (RESOLVE, 2018). This means that even in the states that do have some form of a mandate, people may still struggle to have their infertility treatments covered. Some companies and providers use the medical definition of infertility to justify their inadequate infertility policies. In her interview with physicians and top executives from both United Healthcare and Aetna, Fairyington (2015) highlighted that policies do not provide a pregnancy benefit but a benefit to those who meet the medical, evidence-based definition of infertility.

It is the biased interpretation of how infertility should be defined that disenfranchises many groups. Some state policies deny fertility support to parties that cannot necessarily meet the guidelines for infertility because they may not have engaged in 12 months of heterosexual intercourse without success in forming an embryo (including single men, single women, and LGBTQIA+ couples) (ASRM Ethics Committee, 2015; Weigel et al., 2020). For benefits, such as fertility preservation, an individual would have to have suffered from an iatrogenic condition--that is, infertility that resulted directly or indirectly from a healthcare provider performing a medical procedure (i.e. surgery) or treating a medical condition (i.e. use of radiation) (Campo-Engelstein, 2010). While it would seem that this would apply to transgender individuals receiving mendical care, gender-affirming medical and surgical treatments are not consider iatrogenic conditions (Weigel et al., 2020). Additionally, some insurance companies exclude coverage for all men, both single and married, as women are traditionally viewed as the main factor in infertility (Dupree, 2016).

A CASE FOR FEDERALLY MANDATED INSURANCE

Federally mandated insurance is essential to ensuring that infertility is recognized and treated as a disease. This mandate would open the door for social workers to advocate for marginalized groups, such as LGBTQ+ couples and men, ensuring that insurance policies do not exclude certain groups on the basis of society's definition of who can or cannot experience infertility. Two previously introduced pieces of legislation would require all insurance companies to mandate coverage for infertility treatments: the Family Building Act (2009, 2007, 2003, 2005) and the Medicare Infertility Coverage Act (2005, 2003). The Family Building Act of 2009 stipulated that all healthcare plans should offer infertility treatment benefits (Family Building Act, 2009; Holtzman, 2013). The Medicare Infertility Coverage Act of 2005 was an amendment to Medicare aimed at covering infertility treatments for those entitled to the benefit because of a disability (Holtzman, 2013; US Government Publishing Office, 2005).

Two other major pieces of legislation, the Patient Protection Act and the Affordable Care Act, expanded health care, but neither addressed the issue of coverage for infertility treatments. The idea of infertility as a disability was introduced in 1998 with Bragdon v. Abbott, during which the Supreme Court ruled that reproduction was “a major life activity” that should be protected under the Americans with Disabilities Act (Hawkins, 2007, p. 209). However, the ruling only ensured employers could not discriminate against an individual based on infertility and did not expand the mandate to cover infertility in company insurance plans. Consequently, insurance companies could still promote ableism by denying coverage to those physically unable to conceive through heterosexual intercourse. While the Patient Protection and Affordable Care Acts expanded health care, these laws did not address the issue of coverage for infertility treatments (Norris, 2020). Unfortunately, both the Family Building Act and the Medicare Infertility Coverage Act never made it to Congress for a vote.

Opponents of federally mandated infertility treatment coverage have argued that covering infertility treatments would come at a high cost. Yet, data from Massachusetts, Connecticut, and Rhode Island indicate that state-mandated infertility coverage does not significantly raise premiums. In the 30 years these states have been mandating infertility coverage, the cost is less than 1% of total premium costs (EMD Serono 2019; Wigel et al., 2020). Another argument is the social cost of infertility treatments. Those able to conceive through intercourse are reluctant to bear the costs of treatment for those who experience infertility (Hawkins, 2007). However, the very nature of health insurance demands that individual clients pay for treatments that they themselves may never receive. Though an individual client may never struggle with infertility, or for that matter, heart disease or cancer, insurance companies have always collected payments from these clients to ensure a large pool of resources. The barrier to federally mandated coverage encourages a system where groups are marginalized and systematically robbed of the right to become parents. However, until legislation is in place, many couples struggling with infertility must apply for grants and loans or use personal funds to assist themselves in becoming parents.

IMPLICATIONS FOR SOCIAL WORK PRACTICE

As social workers, supporting couples with infertility can be challenging given the lack of federally mandated insurance coverage for infertility treatment. With the distress that a diagnosis of infertility may cause, social workers may face the difficult task of helping clients find viable options for conceiving a child or accepting the reality that parenthood may not be possible. In 2007, the National Association of Perinatal Social Workers introduced standards for social work provision in infertility treatment centers to assist social workers helping clients navigate the mental, emotional, physical, and financial demands of infertility. Supporting couples experiencing infertility can be challenging given the dearth of policies that legitimize infertility as a disease, as well as the groups of people infertility can impact.

In 1987, obstetrician-gynecologist (OBGYN) social worker Sima K. Needleman recognized that social workers would play an integral role in supporting clients dealing with infertility. In her article, Needleman (1987) describes the psychosocial impact of infertility.including the trauma that could result from learning of infertility and the emotions often associated with trying to decide how or even if to move forward with pursuing alternate paths to parenthood. While the therapeutic responsibility of the social worker is vital to improving the mental and emotional well-being of the client, “infertility is not only a medical and emotional dilemma; in many ways it is also a social problem” (Needleman, 1987, p.136). Social workers must think beyond therapy to being advocates for clients facing infertility.

Given the lack of recognition around infertility as a disease, one of the key ingredients in advocating for policy change surrounding infertility is redefining infertility for lawmakers and insurance companies. For example, social workers may spread awareness of how psychologically damaging the experience of infertility can be. A study of 200 couples undergoing fertility treatments found that approximately 50% of women and 15% of men stated that infertility was the most devastating experience of their lives (Freeman et al., 1985).

Social workers can advocate for policies that motivate or even incentivize insurance companies to recognize infertility as a disease and to provide coverage for infertility treatment, which can give a sense of hope to those who might see no other path to parenthood. Federally mandated insurance coverage would allow those individuals to undergo treatment for infertility without having to worry about significant out-of-pocket expenses. Policies offering incentives for companies that provide support for alternatives, such as adoption, may increase the number of organizations that will provide funding, so individuals can realize their dreams of becoming parents. Demonstrating how becoming a parent helps improve the emotional and mental well-being of a client may be critical in changing the minds of lawmakers at all levels.

CONCLUSION

Misconceptions about conception abound: that conceiving a child is an easy process, that only heterosexual couples can conceive, that problems with fertility originate with women, and that all child-free couples are child-free by choice. In contrast, few are aware that numerous individuals wake up every morning questioning their existence because they are unable to conceive a child naturally, a dream so central to their sense of personhood and identity. In addition, few healthcare providers and lawmakers realize the discriminatory effects of one-dimensional definitions of fertility and reproduction. If society understood the circumstances beyond peoples' control that lead to infertility, then we could collectively embrace the reality that infertility is a disease and those suffering from it need the same level of care and support as those suffering from other diseases.

Society must recognize that regardless of race, class, sexual orientation, or gender, any person may one day find that they are infertile. This public awareness is the first step to establishing universal laws and policies that federally mandate coverage for infertility treatments and accelerating conversations that aim toward deconstructing a system that alienates certain groups from receiving the treatment and care necessary to start a family. This deconstruction includes reimagining the current definitions used to identify who qualifies for fertility treatments and infertility coverage. Social work practitioners are critical to helping those with infertility overcome mental and emotional trauma. As such, they can be catalysts for changing narratives about infertility by highlighting systems of privilege at work in denying some the right to parenthood. Social workers are often voices for the voiceless and should be the leading advocates for federal laws and policies that promote equality and equity in infertility insurance coverage. Everyone deserves the chance to build a family.

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Peer Support as a Tool for Community Care: “Nothing About Us, Without Us”

SHINJINI BAKSHI
THEY, THEM
GUEST ON ANCESTRAL LANDS OF THE INDIGENOUS CHINOOK PEOPLES

In the face of socio-political marginalization, frontline communities reclaim power by harnessing peer wisdom and resilience. The year 2020 marked the confluence of a global pandemic and widespread resistance against anti-Black racism and police violence, highlighting the value of peer voices and community perspectives. To dismantle and transcend carceral approaches to community care, the field of social work is invited to join a larger anti-carceral mental health movement that honors lived experience and works alongside peers to build identity-affirming structures of mental health care. This article examines the ways in which frontline communities benefit from expanded access to anti-carceral formal and informal peer support as a mental health safety net that interrupts harm and prioritizes agency, consent, and self-determination. This paper broadens social work’s conceptualization of peer support through theoretical frameworks of anti-carceral social work, abolition, and intersectionality. Social work and its adjacent fields are called to urgently center Black liberation, collective healing, and community care by advocating for the integration of formal and informal peer support into mental health policy and practice. This paper strategically leans into a lineage of critical peer thought scholarship by utilizing footnotes and citations to model the ethical acknowledgment of peer labor within human rights movements. This intentional structure promotes radical solidarity that resists the exploitation of people with lived experience.

Keywords: social work, peer support, mental health, anti-carceral, lived experience

PEER SUPPORT[1] AS A TOOL FOR COMMUNITY CARE: “NOTHING ABOUT US, WITHOUT US”[2]

The expression “nothing about us, without us” has long been used as a cornerstone of social justice movements. The United States (U.S.) Disability Justice Movement first utilized this expression in the 1990s to amplify historically silenced voices and promote community-based empowerment (Charlton, 1998; Franits, 2005). Social work activists from frontline communities[3] continue to highlight the need for policy initiatives and social change movements to be catalyzed by peers[4] with lived experience and culturally specific understandings of community care. This rallying cry demands that Black liberation and anti-carceral[5] approaches to mental health center Black communities and those most impacted by carceral systems. This anchoring socio-political demand serves as a guide for the field of social work to organize and mobilize itself towards community-led social change and collective liberation.

In 2020, Black, Indigenous, and other people of color (BIPOC)[6] labored at the forefront of the liberation struggle against racial, economic, and gender injustice created by white supremacy. In response to the horrific murders of George Floyd, Breonna Taylor, and countless other Black individuals, Black activists sparked a global call-to-action to dismantle white supremacy, prompting a national uprising against the racist U.S. policing system. Indigenous, Black, and Pacific Islander individuals tragically suffered vastly disproportionate impacts from COVID-19. U.S. failure to respond to this racialized public health crisis caused widespread outcry as members from these communities turned to mutual aid[7] to confront legacies of medical racism and working-class struggle (APM, n.d.). Trans and Gender Expansive (TGE) young people demanded responses to the epidemic of fatal individual and state violence fueled by “anti-Black transmisogyny”[8] (Human Rights Campaign, 2020). Resilient communities on the frontlines of racial, economic, and gender oppression build power through grassroots coalitions oriented towards collective liberation that affirms humanity and provides access to resources.

The Black Lives Matter (BLM) Movement bridged these social concerns, generating cross-movement solidarity by putting a spotlight on the nation’s systems rooted in white supremacy—including the U.S. mental health system. As a socio-political movement for human rights, BLM exposes the ways in which carceral responses to mental health crises limit individuals’ freedom and rights to self-determination through involuntary psychiatric hospitalization, seclusion, physical or chemical restraint, and forced medication compliance. In 2015, people unable to access mental health resources were 16 times more likely than other individuals to be fatally shot during an encounter with police, yet armed police officers were still the default response to people experiencing emotional distress (Fuller, et al., 2015). A 2019 study conducted among

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[1] “Peer support” will refer to empathy, encouragement, and assistance related to emotional wellness (Penney, 2020).

[2] In Critical Disability Studies, activists use this declaration to ensure frontline communities have direct access to shaping policy. This phrase also demands that policymakers remain accountable to communities that have the most at stake regarding carceral approaches to care (Yarbrough, 2020).

[3] “Frontline communities,” a term originating from the Environmental Justice Movement, will refer to communities facing the direct impacts of racial and social injustices from oppressive systems (Front and Centered, 2020).

[4] The term “peer” refers to individuals with “lived experience,” or first-hand knowledge gained from mental health difference or disability (Mental Health America [MHA], n.d.).

[5] “Anti-carceral” mental health uses an abolitionist lens to reject punitive responses to disability or difference, and centers Black liberation (the self-determination of Black people) (Kim, 2018; Critical Resistance, n.d.).
“Anti-carceral” frameworks actively interrogate carcerality, defined in Critical Carceral Studies as dominant societal structures featuring punishment, discipline, social control, and surveillance (Graby, 2015).

[6] Acknowledging that the popularized term “BIPOC” does not capture the vast nuance across different racialized experiences of racism, this paper will utilize this term in place of “communities (or people) of color” to decenter whiteness and highlight the distinct differences present in Black and Indigenous experiences of race and racism.

[7] “Mutual aid” is a political action and organizing strategy that resists capitalist and colonialist forces through networks of radical community care that provide crisis relief to under-resourced communities (Spade, 2020).

[8] “Anti-Black transmisogyny” refers to the targeting of Black, transgender feminine (trans femme) and trans and gender-expansive (TGE) individuals (Human Rights Campaign, 2020). Despite discrimination, prejudice, and inequity, Black trans femme activist-organizers continue to lead innovative social change initiatives (Ware, 2017).

young Black men in Baltimore found that individuals with mental health diagnoses were more likely to experience police brutality (Smith Lee, 2019). Anti-carceral logic proposes a radically different approach to the mental health movement, embracing traditions of interdependence and emphasizing social connectedness while utilizing a critical systems analysis to interrupt carceral response. Social work's purpose in an anti-carceral mental health movement must be not only to center the wellness of those most impacted by violence and oppression, but also to uproot methods of carceral intervention, prioritize self-determination in mental health policy, and reimagine the role of peers in new community structures of life-affirming care (Jacobs et al., 2020).

AMPLIFYING LIVED EXPERIENCE: "EXISTENCE IS RESISTANCE"[9]

There have long been challenges within the field of mental health to standardize the definition of "peer" and to evaluate the benefits of peer roles in care settings. In formal treatment or recovery settings, a peer supporter is "someone who has experienced the healing process of recovery from psychiatric, traumatic, or substance use challenges and, as a result, offers support to promote recovery in traditional mental health settings" (iNAPS, 2013, p. 9). While most formalized systems in society do not favor positioning peers as leaders, social work can abandon the status quo of institutionalized definitions by advocating for the inclusion of peers in all forms of mental health care delivery.

DRAFTING DEFINITIONS – THE ROLE OF THE PEER

In an attempt to highlight the value of peer perspectives in social work policy and practice, social work professionals often use the term "embodied knowing" to refer to knowledge that is gained through and residing within the body (Sodhi & Cohen, 2011; Fox, 2016). This paper defines a "peer" as an equal, or "someone like me [(or you)]," with shared social or demographic identity and lived experience (Shalaby, 2020; Okoro, 2018, p. 2; Penney, 2020). This definition has been criticized for being too broad, as it universalizes and essentializes peer identity and oversimplifies group identity, overlooking differences to meet certain goals (Voronka, 2016). However, this working definition's broad nature intentionally resists urges to professionalize this distinct identity and allows individuals to articulate lived experiences.

CENTERING JUSTICE: "RHYTHM WITHOUT THE BLUES"[10]

Social work will benefit from following an intersectional Disability Justice approach, operating from the awareness that those "most impacted by the legacies of anti-Black racism, colonialism, heterosexism, white supremacy, patriarchal capitalism are the ones furthest from justice and access to self-determination" (White, 2020). Created by disabled[11] Queer, Transgender, Black, Indigenous, People of Color (QTBIPOC) activists, Disability Justice frameworks aim to dismantle "intersecting legacies of white supremacy, colonial capitalism, gendered oppression, and ableism" (Project Lets, n.d., para. 3). In her Matrix of Domination theory, Patricia Hill Collins demonstrates how ableism interlocks with other forms of oppression (2000). Through the adjacent intersectionality theory, Black feminists and critical race theorists assert that carceral ableism (socially constructed ideas of difference or divergence) criminalizes and devalues bodies and minds (Crenshaw, 1991; Lewis, 2020; Berne, 2015).

EMBRACING ANTI-CARCERAL SOCIAL WORK: "THE WATER WE ARE SWIMMING IN"[12]

Social work has been slow to recognize and implement liberatory

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[9] This phrase honors trans activists who have resisted and continue to resist social erasure by bringing visibility to socially marginalized and politically disenfranchised communities (Seidman, 2019).

[10] This phrase has inspired community resilience, validating lived experience of BIPOC and TGE individuals and highlighting the Black Feminist Movement's spirit and message (Collins, 2000).

[11] Following leadership from disabled peers in the Disability Justice movement, this paper uses identity-first language, positioning disability as an identity to affirm the lived experiences of peers (People with Disability, n.d.).

[12] This phrase provides insight into the pervasive anti-Black racism and white supremacy culture in the U.S. and embodies a call to dismantle systems of oppression through social activism (Finn & Jacobson, 2003).

potentials of anti-carcerality and calls for an empowerment-focused paradigm shift to abolitionist praxis[13] (Richie & Martensen, 2019; Finn & Jacobson, 2003). The field continues to uphold and perpetuate white supremacy by utilizing carceral interventions through mental health, criminal-legal, child welfare, and even non-profit systems. Anti-carceral social work interrupts the carceral state, not only addressing prisons, jails, and policing, but also carceral cultures of social control embedded within mental health systems.

Police brutality is a social determinant of health impacting the emotional well-being of racialized individuals and contributing to mistrust of medical institutions (Alang et al., 2020; Bor et al., 2018; McLeod et al., 2019). Narrative accounts of young Black men ages 18-24 summarize feelings of mental anguish related to police violence, stating that police are their "number one fear in life" (Smith Lee, 2019, p. 156). Disabled BIPOC students and adults experience a disproportionate use of physical restraint compared to their white counterparts (Katsiyannis et al., 2020; Cusack et al., 2018). Black liberation challenges theories of crime and punishment by building anti-carceral, peer-led systems of community mental health care.

CRITICALLY CONSCIOUS METHODOLOGY: "PEOPLE NOT PROFIT"[14]

This theoretical article aims to expand the concept of "peer support" by examining narrow, rigid, and de-politicized applications of the term in empirical research. Search criteria included "formal peer support," service providers in mental health settings, and "informal peer support," community-based providers in non-traditional mental health programs. This analysis explores the theory base (specifically within the English language) on Disability Justice and carceral ableism, qualitative data related to the provision of peer support in mental health contexts, and organizational patterns present in past and current social justice movements. The complexities within both the ongoing BLM Movement and current socio-political climate influenced the range of literature reviewed for this article.

REFRAMING POSITIONALITY: "THE PERSONAL IS POLITICAL"[15]

Individuals involved in "peer-run" organizations, such as the Consumer Voices Are Born (CVAB)-REACH center, exemplify the invaluable power of peer-based feedback, perspective, and approaches to care:

> We did not learn about mental health from a textbook, but from our own lived experience. We use this mutuality of experience to connect with others and help our community to see that recovery is an achievable reality. (REACH Center, n.d., para. 1)

Elevating lived experience and acknowledging power dynamics present in empirical knowledge production is crucial in engaging anti-racist work within academia. Intersections of race, gender, mental health, and disability are not just theoretical and academic subjects on which I write, but also experiences I live. Writing this article required my own emotional labor to survive professionally in taxing academic and clinical spaces, and to emotionally synthesize information from personal lived experience related to carceral culture in psychiatric institutions and harm within mental health care systems. As a guest on Indigenous Chinook land and a queer, non-binary person with class privilege and fluctuating

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[13] "Abolition" is a long-term political vision, organizing tool, and broad strategy aiming to eliminate imprisonment and policing while creating lasting alternatives to violence and harm (Critical Resistance, n.d.). Abolitionists do not support any extension of carceral punishment, including in mental health settings.

[14] This phrase serves as a reminder that academic knowledge production is not neutral, and academia must side with frontline communities over institutional, elite, or corporate interests. In anti-colonial, anti-carceral academia, margins of society should not be a "site for domination but a place of resistance" (hooks, 1990, p. 343). Social workers break norms of scientific exploitation in under-resourced communities by concentrating efforts towards shifting power to peers with lived experience.

[15] Critical discourses within Feminist and Student Movements encourage scholars to reject the "myth of objectivity" and "hierarchy of credibility" by actively acknowledging positionality and access to power (Yarbrough, 2020). While frontline communities have been historically excluded from decision making processes that traditionally center voices of (often socially-removed) political stakeholders, this revolutionary saying positions peers as valuable leaders in community care (Barker, 2017).

abilities, I am a consumer-provider of mental health care invested in expanding access to anti-carceral frameworks that prioritize freedom of choice in service of inter generational healing.. I am not directly impacted by anti-Black police violence, nor have I personally experienced poverty or carcerality in the legal system. Due to the inherent shortcomings in my perspective associated with these positionalities, my work remains accountable to peers most impacted by anti-Black racism and carceral ableism.

This paper pushes back against dominant societal and institutional impulses to pathologize resistance by utilizing social work's tradition of "professional resistance" to illuminate counter-narratives, mobilize scholars to interrogate the academic norm of upholding white supremacy, and confront unequal institutional power relations (Strier & Bershtling, 2016). In an act of solidarity following Professor Ericka Hart's February 2021 announcement of unjust termination from Columbia School of Social Work, this paper was intentionally restructured to amplify the wisdom of lived experience (Hart, 2021). This updated version is intended to be an active form of professional resistance against upholding anti-Black racism, white supremacy, and transphobia as the status quo in academia. Professor Hart's stated lived experience of anti-Black racism mirrors the experiences of many unnamed QTBIPOC and disabled scholars and peers who have also endured traumatic silencing by white supremacist institutions. In academic contexts, such silencing impacts the most marginalized scholars and derails our scholarly efforts. This damaging phenomenon in academia is indicative of a larger social trend in which systemic, institutional, and intersecting personal traumas are overlooked, minimized, and made invisible. Professional resistance counters the ways institutions exert and maintain power, practice coercive control over Black and brown bodies, police our minds, and render us disposable. I offer my peer perspective from the margins to invite others to "see and create, to imagine alternatives, new worlds" (hooks, 1990, p. 341).

UPLIFTING THE PEER: "SOLIDARITY NOT CHARITY"[16]

When Mental Health is viewed as a sociopolitical and ideological movement, in addition to a scientific discipline, social workers can interrogate oppressive legacies, contextualize harm in BIPOC communities, and evaluate transformative potential (Bertolote, 2008). Despite a recent surge in political participation, activist-organizers must be aware of pre-existing Feminist, Indigenous, and Disability Justice Movements being co-opted by individuals without lived experience. As the peer workforce grows, social work must contextualize the anti-carceral mental health movement to prevent tokenization and performative inclusion of peers.

UNPACKING FORMAL PEER SUPPORT: "INTEGRATING INTO A BURNING HOUSE"[17]

With roots in the consumer mental health movement, which worked to expand traditional mental health treatment, peer support has always been tied to a legacy of activism (Van Tosh, 2006). Formal peers validate distinctive emotional distress related to structural experiences of inequity and injustice (Beresford & Russo, 2015). Community-based participatory research has found peers provide support when systems fail to respond to Black community needs in culturally-appropriate ways (Corrigan et al., 2015). Because peers often "speak the same language" (both literally and socioculturally), trusted companionship of empathetic peers more effectively validates experiences of structural oppression, marginalization, and exclusion (Repper, 2013, p. 6; Faulkner & Basset, 2012). Peer support services are proven to provide culturally and developmentally appropriate care for young people (ages 16-24) with serious mental illness (Ojeda et al., 2020). Additionally, a U.S. clinical trial surveyed adults with mental illness who had been hospitalized three or more times in 18 months and were at risk for recurrent psychiatric hospitalizations. Compared to

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[16] This phrase underscores the importance of mutual aid community organizing in times of crisis (Spade, 2020).

[17] This quote from Dr. Martin Luther King Jr., questions the sustainability of social reform movements that do not build social structures anew (Alfieri, 2011).

those receiving only standard care, individuals with peer support had fewer readmissions and were hospitalized for nine fewer days (Sledge et al., 2011). Peer insight on clinical teams improved relationships with providers, increased engagement with treatment, reduced symptoms of depression, and improved general recovery outcomes for those with severe mental illness (Puschner et al., 2019; Chinman et al., 2014). Finally, inclusion of peers in social work education has also proven to expand professional compassion and shift clinical faculty attitudes (Repper & Watson, 2012).

EXAMINING THE CREDIBILITY GAP: "POWER IN THE PEOPLE"[18]

Some recipients of care prefer working with licensed mental health professionals due to the notion that such clinicians are more competent in providing care than practitioners with lived experience (known as professionalized peers). Due to lingering stigma, many mental health providers with lived experience choose not to self-disclose commonality (Harris et al., 2016). Clinicians with lived experience are often labeled as "unreliable, dangerous, vulnerable, unpredictable, and lack[ing in] the capacity to occupy esteemed roles such as educators" or contribute meaningfully in clinical and academic settings (Dorozenko et al., 2016, p. 906). Peers with professional competency or clinical skills can be seen as unrepresentative of others experiencing marginalization within mental health systems (Fox, 2020). Licensed and professionalized clinicians without lived experience often perpetuate stigma by expressing skepticism about the integrity and safety of professionalized peers. This devaluing, by both individuals seeking treatment and other clinicians, silences peer voices in academia and clinical practice.

Clinical use of diagnostic criteria from the Diagnostic and Statistical Manual of Mental Disorders (DSM) further reinforces "risk consciousness," referring to the hyper-medicalized focus on solely assessing and managing mental health risk factors, as opposed to also harnessing protective factors such as community and cultural strength (Davidson et al., 2016). The societal shift back to the risk rhetoric of the early mental health movement demonstrates a stronghold of oppressive "one size fits all" Western norms and ableist and colonialist belief systems on mental health practice (Ostrow & Adams, 2012). Formal treatment or recovery settings require the peer workforce to abandon more radical peer philosophies, such as the right to refuse treatment, forcing instead adherence to standard medical models that prioritize identifying dysfunction, managing crisis, and eradicating mental health symptoms.

EVALUATING INFORMAL PEER SUPPORT: "THE REVOLUTION WILL NOT BE FUNDED" [19]

When larger social systems fail to ensure equitable access to mental health support, peer-led mutual aid provides (and has historically provided) prevention-centered crisis relief without reliance on harmful systems. With roots in the Psychiatric Survivor Movement,[20] informal peer support operates outside of institutions, non-profits, and other service delivery systems, and aligns with politically radical legacies of community-led mutual aid (Emerick, 1991; Gagne et al., 2018).

Informal peer support is a unique method of engagement for people who have historically distrusted more formal resources or felt alienated from traditional health services (Simpson et al., 2018; Watson, 2017). Informal peer relationships utilize shared power to normalize neurodiversity,[21] challenge social stigma, and strengthen community ties (Gillard et al., 2015). Relationships with informal peers who have shared cultural backgrounds or values are helpful in navigating systems that continue to perpetuate ableism and social stigma (Faulkner & Basset,

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[18] Variations of this organizing phrase have encouraged communities and individuals globally to build collective community power and to funnel resources into the margins of society (Lisson, 2018).

[19] BIPOC feminists in the Anti-Violence Movement criticize the de-mobilizing effects of non-profit involvement in social justice movements—a phenomenon known as the Non-Profit Industrial Complex (Smith, 2007).

[20] Stemming from 1960s Civil Rights Movement, the Psychiatric Survivor Movement addressed people's experiences of violence in traditional carceral mental health institutions and served as a catalyst, organizing individuals to advocate for the right to refuse treatment and freedom to choose alternatives that centered self-determination, agency, and consent (McLean, 2000).

[21] The Neurodiversity Movement has roots in the Disability Justice and Mental Health Survivor Movements, promoting the need for disability solidarity and recognition of variations in neurocognition (Graby, 2015).

2012). One study found Black college students preferred informal peer support over formal counseling, as peer support honored their culturally-specific coping styles (Grier-Reed, 2013). As evidenced by this qualitative data, social work must create pathways for peer innovation.

ENVISIONING LIBERATORY FUTURES: "SHOW ME WHAT COMMUNITY LOOKS LIKE"[22]

In 2015, 75% of people who called the National Suicide Prevention Hotline were able to actively engage and collaborate with volunteers, as well as de-escalate risk level, despite being initially labeled as an imminent risk of completing suicide (Draper et al., 2015). By contrast, most U.S. crisis hotlines maintain policies for initiating in-person police response for their callers—a protocol known as "active rescue" (Trans Lifeline, 2020b). Because research suggests that effective crisis intervention and de-escalation often render police intervention unnecessary, frontline communities continue to develop anti-carceral, peer-led mental health care alternatives rooted in mutual aid (Leach et al., 2019). In BIPOC communities, peer-led mutual aid has always been a central survival strategy to interrupt institutional harm, prioritizing community care over carceral response, and building momentum towards liberation (Crane et al., 2020; Spade, 2020).

Following a peer-led approach, Trans Lifeline developed a crisis line "for the trans community, by the trans community" (Trans Lifeline, 2020a, para. 1). TGE peers intimately understand that police response to disabled peers experiencing mental health crisis yields a high likelihood of police use of harm, forced hospitalization, and deadly force (Trans Lifeline, 2020b). Trans Lifeline demonstrates how to "informally" fill a culturally-specific mental health need through use of radical collective care policy. The line mitigates violent policing of the trans community through a consensual active rescue policy, never involving police in mental health crises without a caller's explicit consent. Although other crisis lines argue that Trans Lifeline's policy poses liability risks, this policy aligns with the socio-political peer philosophy of preserving the right to self-determination above all else. TGE callers consistently report feeling unsafe calling other crisis lines due to fears around denial of treatment, police interaction, harassment in hospitals, and general transphobic violence. This intentional anti-carceral approach allows TGE callers to affirm the relational importance of reaching out for support, as opposed to avoiding any form of care for fear of harm. Serving as a poignant example of anti-carceral peer-developed alternatives built through grassroots funding, Trans Lifeline is the only U.S. mental health line that has implemented an effective policy against non-consensual active rescue (Trans Lifeline, 2020b).

INVITING DISCUSSION: "DISMANTLE, BUILD, CHANGE"[23]

Communities continue to be "sites for prevention, intervention, and transformation, spaces where interventions can be imagined, initiated, and implemented" (Kim, 2018, p. 227). With five million Black and "Latine"[24] people predicted to lose health insurance due to a loss of employment from COVID-19, the pandemic highlights ongoing racism present in the accessibility of behavioral healthcare (SAMHSA, n.d.; Sloan et al., 2020). The mental health field is pressed to tend to psychosocial needs of frontline communities coping with compounding threats to well-being (Fisher et al., 2020; Jadwisiak, 2020). As social support is a protective factor for well-being, peer support is well-positioned to address limited access to culturally-responsive mental health care (Faulkner & Basset, 2012). Peer support is culturally beneficial to minoritized adolescents with adverse childhood experiences, as well as to those experiencing suicidality (Brinker, 2017). Making radical changes to systemic structures acknowledges histories of empowered BIPOC communities pushing for social liberation.

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[22] This variation of the bedrock protest slogan "this is what democracy looks like" merges organizing and activism efforts to mobilize communities towards collective change (Gillum, 2019).

[23] This phrase grew out of abolitionist frameworks to dismantle the Prison Industrial Complex (Critical Resistance, n.d.). In mental health, it includes building sustainable alternatives that value community-wide healing.

[24] As opposed to "Latinx," "Latine" is a non-anglicized, gender-neutral term describing Latin American people (Gutierrez, 2020).

EXPOSING LIMITATIONS: “SILENCE IS VIOLENCE”[25]

While extant literature speaks to the lived experiences of some marginalized groups, the overall dearth of research within this area misrepresents and distorts unique individual experiences of people with multiple marginalized identities. The divide between academic scholarship and community needs directly relates to how colonialist research institutions continue to objectify, extract from, and profit off of BIPOC without tending to their unique socio-political demands. This alarming observation overshadows drawbacks in the literature, which include vague understandings of peer support mechanisms. *Solidarity research*[26] specifically engages frontline communities in critical political dialogue and change-oriented goal setting, while empirical research generally upholds harmful colonialist notions of objectivity and scientific expertise, thus preventing peers with lived experience from producing knowledge within academic systems (Yarbrough, 2019). Honoring expertise gained through lived experience and legitimizing labor involved in informal peer support does not necessitate empirical evidence. Due to this lack of empirical “expertise,” it is unlikely informal peer support will receive access to certain funding streams. Communities will continue to build solidarity in the margins and will respond in the ways they always have when systems have failed them: by determining what works best for them culturally, regardless of an empirical evidence base.

The limited empirical literature on crisis work is predominantly written through a white cisgender lens. Such a lens produces under-developed theories that inadequately respond to the specific needs of disabled QTBIPOC and fail to acknowledge the unique ways individuals within this demographic experience complex trauma, relate to intersecting identities, and navigate oppressive mental health care systems. Although developing clear models of peer support would aid future studies, professionalizing peer support may restrict the healing nature of holistic relational dynamics (Faulkner & Basset, 2012). Independent of current failing systems, communities will continue developing structures of mutual aid-based informal peer support, warranting urgent advocacy to include peer support in all mental health care delivery.

ENGAGING RADICAL IMAGINATIONS: “PANDEMIC AS PORTAL”[27]

Anti-carceral social work aligns with the assertion that “there can be no health equity when certain groups fear the harm and murder of their families and community by the state” (Jacobs, et al., 2020, p. 19). Engaging true mutuality with one another requires shifting leadership structures from dominant groups to those most impacted by ableism, anti-Black racism, and transphobia. Peer support is both an abolitionist act of care and an embodiment of mutual aid. Moving forward, social workers are called to interrogate the currently existing frameworks around mental health by examining sociopolitical influences preventing peers from being cultural agents of change (Gillard, 2019). Social workers are invited to apply an anti-colonialist, anti-carceral lens to qualitative inquiry and to uplift the work of peers (Yarbrough, 2020; Archer-Kuhn, 2020). Social policy experts consider how an informal peer support safety net may alleviate burdens and costs of mental health care delivery through public health saving (Puschner et al., 2019; Young, 2020). Clinicians have the power to break from reliance on policing and carceral interventions. Until there are more sustainable solutions to compounding social crises, social workers can ensure frontline communities are leading conversations about anti-carceral care.

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[25] Despite social work’s ethical obligation to social justice, the field has perpetuated white supremacy through silence on ongoing anti-Black racism (National Association of Social Workers North Carolina Chapter [NASW-NC], 2020). This saying speaks to the colonialist roots of anti-Black racism and violence in research (Women Scientists Leadership, 2020).

[26] “Solidarity research” diverges from participatory action research in that it resists tokenization by affirming marginalized groups as experts and by focusing data collection and political analysis on critical dialogue of policy-relevant “structural sources of group-differentiated stratification and harm” (Yarbrough, 2019, p. 62).

[27] Arundhati Roy’s April 2020 piece in the Financial Times provides global context of the pandemic and encourages a break with the past, collectively reimagining a more liberatory future.

DRAWING CONCLUSIONS: “BLACK TRANS LIVES MATTER”[28]

Anti-carceral social work policy and practice require acknowledgment of the radical political contributions of peers with lived experience, willingness to shift power to frontline communities, and investment in Black futures. With new insights into the added socio-political benefit of integrating a peer support safety net into structures of community care, social workers can push the field of mental health towards its anti-carceral future. Individuals with lived experience are not only worthy of dignity, care, and healing, but they are also paramount in driving innovation and leading movements towards liberation. Integrating this ideological truth into practice will help future generations of social workers and mental health practitioners minimize emotional distress, repair social harm, and dismantle white supremacy. Social workers rally behind peers and frontline communities to honor the lives of Black trans ancestors and build new liberatory structures of care in which peers can use their collective wisdom, knowledge, and skills to facilitate intergenerational healing.

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[28] Even before the popularized Queer Liberation (LGBTQ+) Movement for gender and sexual justice, Black trans activists paved ways for larger human and civil rights campaigns (Szetela, 2019).

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Mind the Gap: Addressing Childcare Inequalities for Children and Caregivers

JULIANA PINTO MCKEEN
SHE/HER

Formal childcare has been in crisis since its inception. Attempts at regulation and uniformity have been inadequate and culturally insensitive. Seen as a women's issue, it is rarely at the forefront of policy. The topic has recently gripped the national stage due to the ramifications of the COVID-19 pandemic on the childcare industry and its effect on the middle class. While white families who struggle for childcare are currently receiving more attention, Black women and other women of color have been unsupported by the industry. The inadequacy of childcare in the United States upholds racism and sexism. The intersectionality of gender, race, and socioeconomic status plays a large part in the inequitable experiences for Black and Brown children and childcare workers in the United States. The lack of progress in this arena has stifled generations of children, given that research shows quality early childhood education is an optimal vehicle for upward mobility and is correlated with more stable and prosperous adulthoods.

MIND THE GAP: ADDRESSING CHILDCARE INEQUALITIES FOR CHILDREN AND CAREGIVERS

Formal childcare in the United States has been in crisis since its inception. Maternal employment is heavily moralized, affecting the way that childcare is prioritized. Policies delineate clear lines between groups regarding which mothers should and should not work, with Black mothers and other mothers of color being denied the same benefits and protections as white mothers. Black mothers have been working in the United States since they were enslaved (Dow, 2014). After Black Americans were freed, Black mothers continued to work outside the home, often raising white children. Because they were working and could not rear their own children, they leaned on community care for their children. Examples of such community care providers include Black caregivers, housekeepers, wet nurses, and caretakers across history. While widow's pensions, a product of the Progressive Era, were instated to enable white mothers to stay home and care for their children, Black mothers were denied access to these funds and this policy with the justification that they had been working and therefore "should not be encouraged to stay at home to rear their children" (Michel, 2011).

Black women had to work because Black people in America made less money for their labor than white people, a disparity that continues today. While white families could generally live off of the income from one adult, Black families were forced to make ends meet with multiple employed adults. As bell hooks writes, "[B]lack women in the U.S. have always worked outside the home … That work gave meager financial compensation and often interfered with or prevented effective parenting" (hooks, 2015, p. 133). Additionally, Black families were denied the generational wealth owed to them because of slavery and institutional racism. This racism is clear in instances where Black mothers were widowed and not afforded the same benefits under federal policy as white women.

For generations, Black families relied on community care, or fictive kin care, for their children. Examples of such care include older and younger generations within the same family taking care of children, as well as neighbors and friends, or mothers taking children to work, while workers take turns watching the children or everyone keeps an eye on them while labor continues. Fictive kin care was a form of mutual aid and a "normative response to limited economic opportunity" (Miller-Cribbs & Farber, 2008, p. 45). Prior to childcare becoming regulated, and continuing to the present day, fictive kin care was often the only available option for Black families, families of color, and other low-income groups who relied on the financial support of maternal employment.

Since middle- and low-income white women joined the formal workforce, the discussion around the state's role in childcare has grown. The industry has been in crisis because the United States has not definitively decided whether or not white mothers should work outside the home. A long debate regarding the employment of white mothers, who are often portrayed as selfish if they do work (Michel, 2011), continues today and reflects the undervaluing of childcare in our society. Black mothers and other mothers of color continue to experience financial and familial ramifications of generations of racist policies as politicians and the court of public opinion deliberate.

While all parents and guardians are affected by the current state of childcare, this paper centers the experiences of mothers, especially Black mothers and other mothers of color, who are most impacted by lack of access to childcare. The compounding forms of inequality experienced by women of color are pivotal to consider and mitigate. By centering the needs and experiences of Black women and their children, the United States has an opportunity to create impactful childcare policies that benefit all.

HISTORY OF CHILDCARE IN THE UNITED STATES

As Michel (2011) explains, childcare in the United States has seen several iterations since the Progressive Era, 1897-1920. As womens' reforms gained traction, the nation began to discuss childcare. The first nurseries in the country were created by philanthropists and were privately funded through donations. The United States Children's Bureau was created in 1912 and advocated for mothers' pensions, which kept single mothers at home, solidifying the gender roles of the time. The

purpose of these pensions was to enable widows and divorced mothers to "raise their children properly by staying at home" (Abramovitz, 2017, p. 140). The concept of traditional motherhood was seen as patriotic, sometimes compared to the sacrifice of soldiers.

Black mothers were denied access to these pensions due to institutional racism and continued to work outside the home. As Dow (2014) states, "[a]lthough these policies generally only reduced, rather than eliminated, a poor woman's need to work, these pensions underscored that, under ideal circumstances, white mothers should focus on their domestic duties" (p. 38). The concept of pensions was far more popular than the idea of creating childcare programs.

Ward (2005) states, "Political support and motivation for mothers' pensions was grounded not only on the sexist division of labor but on racial discrimination" (p. 50). The birth rate for native-born white children decreased from the nineteenth to twentieth century, coinciding with a large influx of immigrants to the United States. Pensions served the ulterior motive of safeguarding the white middle- and upper-class by ensuring that mothers could focus on mothering, thereby increasing the number of native-born white children.

In the 1920s, the lack of childcare created hazards for children and families, as parents were forced to take children to unsafe work environments or leave them unattended in order to work. Despite documented cases and the rising national problem, the Children's Bureau continued to advocate for pensions over childcare because of the patriarchal notion that women needed to be in the home in order to raise healthy children (Abramovitz, 2017). Experts argued that working mothers were bad for children's development, but they continued to have no issues with Black mothers working outside the home (Michel, 2011). The intersectionality (Krenshaw, 2015) of being mothers and Black women disqualified them from advances in policy.

World War II saw an increase in childcare programs as 6.5 million women entered the workforce (Hartmann, 1998). In 1934, The New Deal established Emergency Nursery Schools, which were partial day programs that operated free of cost to parents. Educators began to consider early childhood pedagogy. While programs operated as childcare, they were designed as schools. By focusing on the benefits of pedagogy for childhood development, creators of these programs were able to sidestep the conversation around women's right to work (Michel, 1999). Much like today, these programs were underfunded and had high staff turnaround, as educators became frustrated with the lack of resources and low wages (Michel, 2011).

The Lanham Act of 1943 approved federal funds for childcare—to this day the only federal law establishing a national childcare program (Ertman, 2019). The investment was insufficient: by federal standards, there should have been one childcare slot for every ten female defense workers. However, as Michel explains, "when the female labor force peaked at 19 million in 1944, only 3,000 child care centers were operating, with a capacity for 130,000 children—far short of the 2 million places that were theoretically needed" (Michel, 2011). Additionally, many programs failed to meet quality and safety standards. Working mothers continued to be viewed as selfish by both society and the government, even as they supplied vital support to the war effort. After the war, the Truman administration cut funding for childcare established under the Lanham Act, as this funding was explicitly tied to wartime needs. Childcare programs were forced to close (Ertman, 2019). The Lanham Act benefitted white mothers and their children, but failed to provide services for Black mothers and families.

The federal government introduced the childcare tax reduction in 1954, offering working families in the formal work force financial relief of childcare costs via a maximum $600 deduction in federal taxes (Buehler, 1998). Adults not in the formal work force did not receive this deduction: domestic workers, handy persons, and those performing forms of employment considered on-call or at-will were excluded. Additionally, the act did nothing about "the supply, distribution, affordability, and quality of child care" (Michel, 2011). The late 1950s saw the emergence of advocacy groups that continued to push for the creation of childcare programs. The Inter-City Committee for Day Care of Children believed that childcare should be provided by the government instead of private charity. They worked with government agencies to make this a reality by gaining federal support for publicly funded childcare (Michel, 2011).

President Kennedy's President's Commission on the Status of Women (PCSW), created in 1961, signaled the federal government's willingness to discuss maternal employment and considered the developmental attributes of childcare, as well as its opportunity to advance integration. As opposed to previous policies that left out Black and Brown[1] Americans, the PCSW introduced the possibility of serving a representative "cross section" of the population for the benefit of "democratic social development" (Front Matter, 1963).

Subsequent administrations, such as Nixon's, only supported childcare efforts for low-income families, curtailing advocacy efforts while continuing to provide tax incentives to employers and middle- and upper-class families. The Reagan era saw far reaching cuts to welfare for low-income families, while expenditures for middle- and high-income families nearly doubled. These economic policies forced the childcare system to shift to for-profit models.

The 1990s brought large investments in childcare via the Child Care and Development Fund (CCDF), but as before, these funds lacked supply and quality. This fund continues to be the main source of government investment in childcare, practically applied by allowing states "significant freedom to coordinate the child care support for low-income families in their state" (Vesely & Anderson, 2009, p. 41). Childcare costs continued to rise, while tax credits did not. The CCDF was created in part as a response to the racialized idea of the "welfare queen" perpetuated by the Reagan administration and exacerbated by Clinton. These administrations were responsible for upholding this myth and exploiting "popular welfare racist attitudes that were well documented by polling and other data" (Doran & Roberts, 2002, p. 402). New policies required proof of work in order to receive benefits, but did not take into account the impact of systemic racism in families' ability to enter the formal

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[1] This paper recognizes that labels and organizations of race and ethnicity cannot fully capture the myriad of racial and ethnic identities and lived experiences. The paper uses the following labels: Black, Brown, and white. The term "Brown" is used to refer to non-Black people of color.

labor market. Politicians did not foresee that the childcare industry would become highly represented by Black and Brown women who are unable to afford the same care for their children that they provide for others.

WAGES AND LACK OF PAY PARITY BETWEEN TEACHERS AND CHILDCARE WORKERS

Although childcare costs are rising for programs and consequently for families, workers' wages are not. Operating costs have a direct impact on the price point for enrolled families. While regulations and costs vary by state, costs largely include liability insurances, supplies, venue, food costs, and payroll. Programs are required to hire the appropriate number of staff based upon the ages of the children served and state-mandated ratios of children to staff. Costs also vary depending on geography. Programs in urban areas cost more to operate than those in rural areas. On average, childcare workers nationwide make $24,600 per year less than K-12 teachers per year (Interlandi, 2018).

The issue of pay parity is at the forefront of advocacy in New York State, as childcare workers in Department of Education funded programs need to meet the same requirements as K-12 teachers but make a fraction of the income. The majority of grade school teachers are white women, while approximately 45% of childcare workers are Black, Latinx, or Asian and are grossly underpaid for their labor (Mueller, 2020). Activist groups continuously demand more funding for subsidies and pay parity between childcare educators and childcare providers. These two professions are often compared and presented as antagonists, with childcare providers seen as inferior and paid as such. For example, in New York City, both early childhood educators working in programs licensed under Article 47 of the health code and grade school teachers require a master's degree and a state teaching certification. However, early childhood educators in New York City earn on average $20,000 less per year (Krien & Mason, 2019). This could be in large part because grade school relies on sizable government investment, while early childhood relies upon families to foot the bill.

Lack of wage theft regulation further compounds the problem.

Childcare is not a profession that you can truly clock out from when your workday is over. If there are children left to watch, you cannot leave them alone. However, a lot of programs do not have overtime pay. While workplace protections do cover childcare workers, nonpayment for labor is commonplace. Some programs are so small, serving less than twenty families, that they operate under the radar of regulators. Childcare operators find themselves in a difficult position, wanting to pay their employees for their work, but knowing this would increase operating costs, which might cause a decrease in enrollment due to families seeking cheaper alternatives. If a program does not take private pay and only uses subsidies and vouchers, it is not their prerogative to offer overtime pay.

Calls to action on childcare exist, but have lacked pivotal investments. In 2019, the Child Care for Working Families Act was introduced, which would provide funds for the Child Care and Development Block Grant and revise it to "create a tiered and transparent system… [and] assure that copayments are based on a sliding scale," among other improvements (Child Care For Working Families Act, 2019). Childcare champions do exist, such as Senator Elizabeth Warren and Representative Rosa DeLauro, among others. This past July, the Childcare Is Essential Act passed in the House but has not made it to the Senate floor. The bill called for $50 billion in federal funding for childcare (Childcare Is Essential Act, 2020). The Biden administration released a plan for childcare as part of their coronavirus rescue package. In this plan, the administration proposes creating a $25 billion stabilization fund to support programs in danger of closing permanently, invest an additional $15 billion in the Child Care and Development Block Grant program, and increase tax credits to cover the costs of childcare (Fox, 2021). These efforts do not address the pay disparity in the industry, but they work to create stability and financial aid for families. The issue of low wages and lack of pay parity coincides with the representation of workers in these industries. The racial makeup of these workers is historically commensurate with the pay they receive, continuing to uphold systems of inequity and oppression.

CHILDCARE AND SOCIAL ISSUES

Childcare continues to be a pain point for families across the nation, even as an estimated 51% of women were in the workforce in 2016 according to the Department of Labor (US Department of Labor, n.d.). Large parts of the childcare system are operated as businesses because government funding is finite, leaving families to pay out of pocket and childcare programs to compete for clientele. A report by the Economic Policy Institute found that in 2019, public spending on childcare and early childhood education totaled about $34 billion, while household spending totaled about $42 billion (Gould & Blair, 2020). The expense creates a push and pull between families and programs; programs constantly attempt to keep costs low for families and are thus unable to pay educators a fair wage. Childcare costs vary from state to state and have been rising in recent years. For example, the cost of childcare for an infant in Mississippi is $453 per month, versus $1,412 in California (Economic Policy Institute, 2020). Across the board, childcare workers are underpaid, with an average annual income of $28,000 per year, and only 15% have access to healthcare through their employers (Interlandi, 2018).

The issue of fair pay overwhelmingly affects Black and Brown women, who make up 45% of childcare workers. Much like in previous generations, disadvantaged women take care of other people's children, while their own children are denied this level of care. Many childcare workers cannot afford to send their children to the same programs that employ them. Generations of inequitable policies have forced two divergent options: upper- and middle class families can send their children to early childhood programs designed to kickstart education using a myriad of different pedagogies and modalities, while lower-class families must rely on a social welfare system to help take care of their kids at sometimes questionable standards. This dynamic introduces another point of intersectionality: socioeconomic status. These options for care of very young children often fall along racial lines, with Black and Brown families most often being forced to utilize the second option. These two modes of care falsely separate care and education, while the two are inextricably linked. Early education teachers indisputably care for their students, and childcare providers undoubtedly educate the children for whom they provide care. This separation serves to drive a wedge between the professions and upholds pay discrepancies.

A solution to disparities in care and education between racial groups and economic classes requires deep investments and culturally relevant pedagogies. The childcare industry is an afterthought in policy and financial decisions. This causes adverse consequences to children, families, and childcare providers. Our society has not eradicated this problem because it is perceived as a women's problem and a problem of low socioeconomic status, thus low priority. At its core, the trivializing of childcare in the United States is a sexist and racist societal policy. History and policies have shown that the nation has decided white mothers should remain at home and Black and Brown mothers should work (Miller, 2019). Quality early childhood education affords children great benefits long into adulthood and is a vehicle for upward mobility, but because many white families can afford childcare, policy makers have not been pushed to find a solution. Early childhood education allows adults in the family to work outside the home if willing and able. It is a venue to help children develop their social skills, growing bodies, and to begin to acclimate to academic environments. The childcare system was unjustly created with white families in mind and continues to suit only their needs.

CHILDCARE POLICIES

Even well-intended broad policy attempts to regulate childcare, an industry that has community-dependent cultural implications, have had negative consequences. Generally, the federal government provides minimal funds, via the Child Care and Development Block Grant, to states to regulate how they see fit. States enact sweeping regulations that dictate which programs and families receive funding. Within states, there are vast differences between communities and jurisdictions. Broad rules do not have equal effects on all participants of the system, in the same way that one curriculum does not suit the needs of all children. The childcare system today is a result of disjointed funding and regulations that do not put children, families, and caregivers at the center. Policies have failed because they fragment the system and allocate insufficient funds.

On a micro level, there is a significant impact on children and families. Supply issues in parts of the country render quality programs hard to come by. Regulations meant to assure a standard of care often increase red tape and create barriers to entry for prospective childcare providers. Calls for reform and for early education programs that also serve as childcare, like Pre-K for All, are good starts. However, because the system is fragmented, they often complicate operations for providers and continuously leave some behind.

For example, since New York City implemented the Universal Pre-K program in 2014 many more children entered early childhood programs. This is beneficial to both the children and their families. Pitfalls include the oversight by an additional agency, the Department of Education, to regulate programs previously only regulated by the Department of Health. Sometimes these agencies have different regulations and both expect providers to meet their regulations, even at the cost of a citation from the other. In practice, this labyrinthine structure means that depending on which agency arrives for an inspection, providers can receive citations and fees for being out of compliance with one agency while abiding by the rules of another.

For New York City children younger than four, families can receive subsidies they can use to pay for childcare. Effectiveness of subsidies is reliant on state and local regulations. Often, programs who accept subsidies are forced to accept less financial recompense for their service and/or be paid much later than the service was provided. Programs that accept subsidies may choose to do so to serve their communities, if families require this aid. When the system works at its best, providers can depend on consistent payment from subsidies. Subsidy payments require maneuvering bureaucracy and paperwork that not all programs have the bandwidth or knowledge to do. Often, subsidies are more beneficial to families than providers (Adams & Snyder, 2003).

On a macro level, there are severe consequences to the wellbeing and social mobility of large swaths of children in our nation. The lack of access to quality early childhood education and childcare for all has economic repercussions for children long into adulthood, for parents–most often mothers--and for childcare providers. Access to early childhood education affords children wellbeing and economic gains long after they have graduated from these programs. Working mothers are good for our country and for mothers themselves. Longitudinal studies have found that mothers' continuous and full time employment is correlated with significantly better mental and physical health at age 40 than mothers who were unemployed, non-continuously employed, or not employed full time (Frech & Damaske, 2012). As discussed above, childcare workers are underpaid and as such, unable to experience social mobility themselves, continuing the cycle of inequality within their families and communities.

Additionally, communities often try to create other venues to provide childcare to those in need, such as legally exempt providers or unlicensed childcare groups. These types of programs mimic community care of past generations. Low-income communities attempt to circumvent the regulations because compliance is often cost prohibitive to families and providers alike. Licensing a program can take months of navigating ever-changing regulations. Barriers to entry include the lack of capital funds, mandated education, and social capital. A lack of research exists on this demographic, perhaps in part due to the potential repercussions of operating an unlicensed program. Childcare policies aimed at regulating funding and formalizing care impede some caregivers from providing care in legal ways. Childcare policies should suit the needs of communities, as opposed to forcing communities to conform to policies that prevent adequate care.

ANTI-RACIST APPROACH TO CHILDCARE: RETHINKING EARLY CHILDHOOD EDUCATION

Quality early childhood care and education are great vehicles of upward mobility. Longitudinal studies show that children who attended early childhood education programs were less likely to become teenage parents, more likely to graduate high school, and more likely to enroll in higher education. In some instances, adults who attended one of these programs had higher median incomes, were less likely to be on welfare, and were less likely to have been arrested (Interlandi, 2018). Investments in children's education, health, and wellbeing are generational investments; the government tends to receive a return on investment with additional capital gains (Hendren & Sprung-Keyser, 2020). As the authors of these studies explain, investments in children have historically yielded the largest Marginal Value of Public Funds, meaning that the policies pay for themselves over time and actually produce money. Equitable access to childcare would be a wise, anti-racist policy that would greatly impact the nation.

An anti-racist approach to solving the issues documented here would be to craft a new system that places the child at the center, values childcare providers and educators, listens to them in the creation of a system, and places a hefty investment in such a system. By redressing past injustices, such as inequalities in access to care and financial aid to Black and Brown mothers, meeting the needs of children and families of color, supporting the whole family, and serving all children and families in need (Minoff et al, 2020), policymakers and advocates can implement anti-racist policies. All families and children should have access to childcare and early childhood education and to the myriad of pedagogies to best suit the child. By creating a system that does center children, families would have options. This is important because the solution is a not a cookie cutter curriculum for all childcare programs and looks different depending on the child, the family, and the community.

There are beautiful models of what this could look like: Afrocentric Montessori programs, bilingual Reggio Emilia programs, and a Lakota Waldorf school. Children have individual needs and learn better using different modalities. Programs that make whole families feel welcome are better suited to meet these needs. The system currently in place was created solely with white families in mind. New policies should support efforts to create culturally relevant early childhood programs that are reflective of the communities they serve. With significant and continuous investment, we can pay childcare providers the wages they deserve. Childcare should be accessible to everyone and should be seen as the public good it really is (University of California, Berkeley, 2018). After all, childcare allows parents to stimulate our economy and safeguards our future: children.

CHILDCARE AND THE COVID-19 PANDEMIC

The pandemic has gravely exacerbated the pitfalls of the childcare system. In July 2020, the National Association for the Education of Young Children (NAEYC) (2020) completed a survey and estimated that 40% of all early childhood education programs would close their doors before the end of the year without government help (Beer, 2020). The CARES Act earmarked a pittance for the struggling industry and made the disbursement at each state's discretion. Although it has never been fully funded by the public, the childcare industry costs around $10 billion per month. The CARES Act earmarked $3.5 billion total for childcare (Bedrick & Daily, 2020). The pandemic has decimated the childcare industry, with programs closing daily. A December 2020 survey by NAEYC found that approximately 42% of programs that have permanently closed due to the pandemic were minority-owned (NAEYC, 2020). In New York State, providers continue to wait for the remaining CARES Act funding that has yet to be disbursed while programs suffer.

This existential crisis has pushed industry, legislators, and activists alike to action. The Child Care is Essential Act was a good start. This bill would have created a Child Care Stabilization Fund with $50 billion to offset the repercussions of the COVID-19 pandemic on the industry (Child Care is Essential Act, 2020). Seeing a bill of that magnitude pass in the House was a momentous event. Senator Elizabeth Warren advocated for childcare on the campaign trail during her bid for the presidency and again during the 2020 Democratic National Convention. Childcare has entered the national conversation. In response to the effects of the COVID-19 pandemic, an exponential number of articles have been written by journalists, economists, pedagogues, and sociologists. Topics include the effects of isolation on children, the effects of a lack of childcare on women in the workforce, and the disproportionate harm to an entire sector of the economy. Folks have seen and felt what is to be without childcare. As families sheltered in their homes for a year, there was a refreshed awareness of the importance of childcare. Now, we must use the catalyst that was 2020 to create lasting changes for childcare.

A COVID-19 stimulus package signed into law in March 2021 included a large benefit to children nationwide: a large expansion to the existing child tax credit, which will benefit 93% of children nationwide (DeParle, 2021). This new law includes provisions that will cut the child poverty rate in half and have an even bigger impact for Black children (Barbaro, 2021). Families will receive monthly checks of up to $300 per child, regardless of the number of children in the family without negating other benefits families receive. The benefit diminishes only when families earn over $150,000 annually. There are no specifications for the ways families can choose to spend these funds. This type of welfare is revolutionary in the United States after the devastating effects of the "welfare queen" myth and the institution of aid contingent on parental employment. The child tax credit is directly tied to the child, as opposed to the guardian, whose actions will have no bearing on the funds. The stimulus package institutes this expansion for one year, after which its extension will require Congressional action.

CONCLUSION

Childcare is a heavily moralized but vital service in the United States, and the inadequacy of childcare is intrinsically tied to race and class. Formal and regulated childcare began in the public realm, was created for white families, and was funded by the government to support war efforts. A lack of necessary funding to childcare programs pushed the industry to privatization, which widened the inequities between white families and all other families. Attempts to publicly fund childcare and early childhood education were seen as opportunities to integrate in the 1960s, but failed to meet this goal. In 2021, inequalities still exist in care between Black and Brown families and white families. The COVID-19 pandemic has widened this gap and concurrently proven the worth of the industry. The March 2021 expansion of the child tax credit is a viable option for combating childhood poverty and simultaneously stabilizing childcare. The nation has an opportunity to reimagine a system that serves our present and our future. Failure to capitalize on this opportunity will further metastasize the generations-long impacts of inequality. The United States can ill-afford to continue to ignore the fact that early childhood education and childcare should serve and be accessible to all families and children.

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Still Fighting: The Relationship Between Contemporary Preemption in the South and the Continued Struggle for Black Worker Rights

RESHA T. SWANSON
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Post-Reconstruction Black Codes implemented throughout the South stunted the economic mobility of Black workers and replicated the free labor system of slavery (Nittle, 2021). While these laws were abandoned or outlawed over time (Nittle, 2021; PBS, 2017), the use of contemporary preemption in Southern states acts as a de facto continuation of Black Codes by barring legislation, often from progressive cities and municipalities, that seeks to strengthen rights and protections for Black workers throughout the region. In order to properly understand the unique racial, political, and economic entanglement between twenty-first century preemption and the oppression of Black workers, one must first explore the origins of preemption and the history of Black worker oppression in the South. This examination provides the backdrop for modern attempts to suppress Black workers in states like Alabama and Tennessee. A closer look at the deep political divisions between Southern legislatures and urban municipalities in their states offer arguments, though unfounded and insufficient, in favor of preemption, and outline the challenges worker advocates face when addressing the problem. Despite its challenges, it is critical for organizers to continue fighting preemption using creative strategies and to reaffirm the rights and advancement of Black workers.

Keywords: preemption, South, Dillon's Rule, Home Rule, Black Codes, workers, oppression

STILL FIGHTING: THE RELATIONSHIP BETWEEN CONTEMPORARY PREEMPTION IN THE SOUTH AND THE CONTINUED STRUGGLE FOR BLACK WORKER RIGHTS

In the South[1], where the shadows of slavery loom long and heavy, the word preemption strikes fear into the hearts of local legislators and worker rights advocates. Preemption is the "use of state law to nullify a municipal ordinance or authority" (DuPuis et al., 2018, p. 3). Predominantly white state legislatures use preemption to strike down ordinances passed by progressive cities, including legislation that raises the minimum wage, mandates paid leave, or advocates for fair workweeks. Through it all, workers from these liberal, urban areas with highly concentrated Black populations—often led by Black and Latinx city councils—suffer the economic consequences (Blair et al., 2020). In short, preemption is more than a tool used by state legislatures to block progressive legislation. It is a racially charged mechanism that has been employed for centuries to perpetuate white supremacy and suppress the rights of Black workers in the South.

This paper explores the historical origins of state preemption, its connection to Black worker suppression, and preemption's manifestation in the twenty-first century South. While this paper focuses on the South, it does not mean to express that preemption does not thrive in Northern states or that its effects are felt only by Southern Black workers. To the contrary, preemption oppresses all working class individuals wherever utilized. "State interference with local decision-making occurs in every region of the country" (Blair et al., 2020, p. 3), but preemption in the South is distinctly shaped by conservative legislatures battling urban, progressive municipalities and cities, typically heavily populated by Black and Latinx individuals, for legislative power, making Southern preemption uniquely racially divisive (Blair et al., 2020). This paper explores racism's deep-seated role in shaping worker-related preemption policies in the Southern region (Blair et al., 2020).

In order to clearly understand contemporary preemption in the South, we must first study its roots in the United States and its context in the region.

THE FRAMEWORK FOR PREEMPTION

Two primary factors worked in tandem to set the stage for contemporary preemption–: (1) the Supreme Court conferring preemption powers to states and (2) the restricted economic mobility of Black workers post-Reconstruction.

DILLON'S RULE AND HOME RULE

The United States Constitution's "Supremacy Clause" clearly defines the hierarchy of authority between federal and state legislation, declaring federal law "the supreme Law of the land" (U.S. Constitution. art. VI, cl. 2.1.1.3). In other words, federal laws overrule state laws in situations where state legislation expressly and impliedly contradicts federal law (Congressional Research Services, 2019). However, the Constitution makes no mention of powers granted to municipalities[2] and cities and their priority in lieu of less or more restrictive state legislation that does not already contradict federal policy. This left the matter in the hands of various courts.

Named after former Iowa Supreme Court Justice John Dillon, Dillon's Rule "derived from the two court decisions issued by Judge John F. Dillon of Iowa in 1868" (National League of Cities, 2016, para. 4). In the first decision, City of Clinton v. Cedar Rapids and Missouri River

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[1] The Deep South (also known as the Lower South) refers to the states of Alabama, Georgia, Louisiana, Mississippi, and South Carolina, whose economies were historically dependent on the production of cotton and slave labor (Beck & Tolnay, 1990). The Upper South, composed of Tennessee, Kentucky, and Missouri, relied less heavily on slave labor and traditionally grew wheat and grain-based crops (Jordan, 1967). Scholarly articles vary in their inclusion of Arkansas and Texas as Deep or Upper South states, but agree that they culturally and economically fall within one or both categories (Beck & Tolnay, 1990; Jordan, 1967). For the purpose of this article, the author uses the term South (and other variations of the word) to refer to states of the Upper and Lower/Deep South areas, and, Texas, Arkansas, North Carolina, and Florida (which share similar economic and cultural histories).

[2] In this article, the term municipality refers to counties, wards, and similar governing bodies that function as "political subdivisions of the state" (Phillips, 2017, pp. 2230-2231).

Railroad Company (1868), "the plaintiff, the City of Clinton, sought to enjoin the defendant, Railroad Company ("Cedar Rapids"), from building railroad tracks across the city's streets without the city's consent" (Hansford, 2020, para. 3). Eventually, "the court held that the city could not prevent Cedar Rapids from building over the streets of the city because the Iowa legislature granted Cedar Rapids the right to do so" (Hansford, 2020, para. 3). Regarding the decision, Judge Dillon wrote:

> The true view is this: Municipal corporations owe their origin to, and derive their powers and rights wholly from, the legislature. It breathes into them the breath of life, without which they cannot exist...Unless there is some constitutional limitation on the right, the legislature might, by a single act, if we can suppose it capable of so great a folly and so great a wrong, sweep from existence all of the municipal corporations in the State, and the corporation could not prevent it. We know of no limitation on this right so far as the corporations themselves are concerned. They are, so to phrase it, the mere tenants at will of the legislature. (City of Clinton v. Cedar Rapids and Missouri River Railroad Company, 24 Iowa 455, 475, 1868)

The second key decision, Merriam v. Moody's Executors (1868), challenged a city's ability to "sell and convey real estate for the non-payment of special taxes" levied in the city's charter (Merriam v. Moody's Executors, 25 Iowa 163, 170). Dillon wrote:

> In determining the question now made, it must be taken for settled law, that a municipal corporation possesses and can exercise the following powers and no others: First, those granted in express words; second, those necessarily implied or necessarily incident to the powers expressly granted ; third, those absolutely essential to the declared objects and purposes of the corporation—not simply convenient, but indispensable; fourth, any fair doubt as to the existence of a power is resolved by the courts against the corporation—against the existence of the power. (Merriam v. Moody's Executors, 25 Iowa 163, 170, 1868)

Justice Dillon would expound on what came to be known as "Dillon's Rule" in five editions of his legal treatise Dillon on the Law of Municipal Corporations (Hansford, 2020). The United States Supreme Court adopted Justice Dillon's analysis in a 1907 decision in Hunter v. Pittsburgh, where the Court declared, "Municipal corporations are political subdivisions of the State, created by it and at all times wholly under its legislative control" (Hunter v. City of Pittsburgh, 207 U.S. 161, 52 L. Ed. 151, 28 S. Ct. 40, 1907).

The most crippling part of Dillon's Rule is the provision that any powers not expressly given to localities have not been conferred, which severely limits municipalities' ability to pass legislation that the state legislature may see as politically unfavorable (National League of Cities, 2016). The National League of Cities (2016) notes, "No local action could be undertaken without permission from the state legislature, which only met for short, biennial sessions…[and] generally requires that local officials spend a considerable amount of time lobbying the state legislature" (para. 6).

Concerned about the restrictive nature of Dillon's Rule, Judge Thomas Cooley held that local governments did possess some power to pass legislation within the bounds of state laws and constitutions (People ex rel. Le Roy v. Hurlbut, 24 Mich. 44, 1871). While Home Rule helped municipalities regain limited power in the early 1900s by "conferring some powers to local governments," its "power is limited to specific fields, and subject to constant judicial interpretation," and was, moreover, defined and applied differently by each state (National League of Cities, 2016, paras. 7-8).

The application of Dillon's Rule and Home Rule is sporadic. Dillon's Rule can be applied to municipalities, cities, or towns with a certain population or chartered before a certain year (or a combination of the two), which is the case in eight states (Russell & Bostrom, 2016). For example, Alabama applies Dillon's Rule to counties but Home Rule to other municipalities like towns and cities (Hansford, 2020). Some states provide for Home Rule through constitutional changes, while others do it through legislative statutes, and states may limit Home Rule to cities, municipalities, or a combination of the two (Russell & Bostrom, 2016).

The uneven application of Dillon's Rule and Home Rule sets the stage for battles over legislative power within states.

A HISTORY OF BLACK WORKER SUPPRESSION

Another key component to understanding contemporary worker rights preemption is the South's torrid history of Black worker suppression.

The Civil War, followed by Reconstruction, upheaved the lives of Southern aristocrats and governing entities. General Sherman's March to the Sea left thousands of Southerners with damaged or no property, burned cities and fields, and deep-seated resentment (PBS, 2021). In addition to economic loss and extensive property damage, many ruling Southern whites also lost their labor source— enslaved Black people—in the years following the Civil War (PBS, 2021). Reconstruction forced former slave owners to live amongst (at least to some extent) their former "subjects" who, thanks to the newly passed Fourteenth and Fifteenth Amendments, were now endowed (theoretically, at least) with the same inalienable rights, and competed for coveted economic and natural resources (United States Senate, 2021).

Intensified by the tight stranglehold of Reconstructionist Northerners, emancipation threw Southern governments into chaos. When President Hayes reversed Reconstruction in 1877 and withdrew troops, Southern, white lawmakers jumped at the opportunity to "disenfranchise Black voters and dismantle the reforms that had been instituted after the Civil War…and restore the racial hierarchy of the pre Civil War political order" (Blair et al., 2020, p. 5). Black Codes or Black Laws were passed, primarily in Southern states, that successfully "limited the rights of Black people and exploited them as a labor source" (Nittle, 2021, para. 1). These laws created a free labor system that mimicked slavery and served as early examples of Southern legislatures using their power to prevent Black people from gaining economic mobility. Black Codes included state legislation like the following:

In addition to criminalizing joblessness for African Americans, the codes required Black people to sign annual labor contracts that ensured they received the lowest pay possible for their work. The codes contained anti-enticement measures to prevent prospective employers from paying Black workers higher wages than their current employers paid them. Failing to sign a labor contract could result in the offender being arrested, sentenced to unpaid labor or fined (Nittle, 2021, para. 7).

Debt peonage also forced Black individuals into free labor. The meager wages paid to Black individuals post-Reconstruction required many, especially those in the agricultural industry, to take out loans from creditors and sharecroppers (PBS, 2017). Additionally, Black people in the South were targeted and surveilled, often culminating in arrests for minor crimes like loitering and leading to exorbitant court fines and fees. (Nittle, 2021; PBS, 2017). Because they lacked economic means, Black people often were mandated or opted to pay back debts via exploitative free labor (PBS, 2017).

Moreover, Black workers endured vast abuses. Paul Worthman's (1969) early survey of Black workers and their relationship to unions noted the appalling conditions of early mines in Birmingham, Alabama, and the animus of white workers against their Black peers. He wrote, "Racial prejudice among Birmingham workers sometimes broke out into open conflict as white working men attempted to eliminate the economic competition from Black workers by barring them from certain trades" (Worthman, 1969, p. 381). Black workers faced not only verbal and physical conflict, but also financial manipulation and abuse from employers. Worthman (1969) described the conditions at the ore mines of Red Mountain: "Ore was dug by subcontractors who hired laborers at 65 cents per day...whether or not they lived at the camps, at least 50 cent per month was deducted for each man's wages for rent" (p. 397).

Dillon's Rule, early Black Codes, and the economic suppression of Black workers set the stage for volatile legislative conflicts over worker rights across the South.

TWENTY-FIRST CENTURY PREEMPTION

Seen through the historical lens of post-Reconstruction, contemporary preemption can be seen as a perhaps more successful continuation of early Black Codes' efforts to limit the mobility of Black workers in the South—successful in the sense of using Dillon's Rule and Home Rule as forces for maintaining a white supremacy that was codified into state law. It is an essential tool for majority white, conservative legislatures hoping to block municipal ordinances that would strengthen the rights of Black workers. The Economic Policy Institute's "Map of the Campaign to Suppress Worker Rights in the States" (2019) indicates that Southern states have some of the most restrictive preemption laws. In these states--Alabama, Arkansas, Florida, Georgia, Louisiana, Mississippi, North Carolina, South Carolina, and Tennessee--state legislatures have stifled local attempts to strengthen worker rights by preempting legislation that altered the minimum wage, established project labor agreements, paid leave, and fair scheduling, instituted prevailing wages, or regulated the gig economy. Unsurprisingly, Black people account for 15% to 27% of these states' populations, significantly higher than the national Black population of 13.4% (U.S. Census Bureau, 2019). Nashville and Birmingham serve as two contemporary examples of preemption in Southern cities and illustrate how its modern-day invocation stifles attempts to expand Black worker rights.

NASHVILLE, TENNESSEE & LOCAL HIRE LAWS (2015)

In 2015, Nashville voters passed a local hire ordinance titled Nashville Metro Chamber Amendment Three, which aimed to create job opportunities for city residents. Amendment Three proposed that for "municipally funded construction projects that cost $100,000 or more, 40% of construction work hours must go to Nashville residents, with 25% of those work hours going to low-income Nashville residents" (Blair et al., 2020, p. 12). In Nashville, 14.5% of construction workers were Black and 46.2% were Latinx, and 45% of all construction workers living in Nashville were born outside the United States (Blair et al., 2020). At that time, 82.6% of Tennessee State Legislators were white (Blair et al., 2020).

A few weeks later, Tennessee's majority Republican Senate struck down Amendment Three. According to Woodman (2016), "Contractors' associations have opposed local-hiring policies across the country as being anti-competitive, discriminatory to nonresidents, and ultimately a job-killer" (para. 12). State Senator Jack Johnson, the Republican who spear-headed the bill, and Attorney General Herbert Slatery argued that the local-hire agreement violated the state's standing Contractors Licensing Act of 1994 (Ebert, 2016). When challenged on whether or not his bill was "overturning the will of the voters of Nashville," Senator Johnson answered, "In fact we are" (Ebert, 2016, para. 6). Progressive Nashville worker-organizing groups recognized this as an attempt by the state to stymie liberal work practices and to suppress Black and Latinx workers in progressive municipalities (Woodman, 2016). Jason Freeman, the co-chair of the Nashville Organized for Action and Hope's Economic Equity and Jobs taskforce, responded by saying, "We're trying to get a handle on how to address systemic poverty but the best tools that are available are, one by one, being taken away from us" (Woodman, 2016, para. 16).

BIRMINGHAM, ALABAMA & MINIMUM WAGE (2016)

Racism obstructed Birmingham's attempt to pass a minimum wage ordinance in 2016. The City of Birmingham is a majority-minority city, with 70.5% of residents identifying as Black compared to the state's overall Black population of 26.8% (U.S. Census Bureau, 2019). In 2016, Birmingham City Council was also majority Black, so it came as no surprise that many saw the City Council's vote to raise Birmingham's minimum wage to $10.10 per hour as a significant victory for Black workers. Within two days, the 75% white Alabama State Legislature passed a bill barring "cities and counties from raising the minimum wage or requiring employers to provide leave or other benefits" (Blair et al., 2020; Roth, 2016, para. 2). The bill applied retroactively, nullifying Birmingham's attempt to rectify economic disparities. There is no state minimum wage in Alabama, so the passage of the bill forced Birmingham to adhere to the federal minimum wage of $7.25 per hour. This legislation not only preempted future attempts to raise the minimum wage, but it blocked any future efforts by municipalities to strengthen worker rights policies beyond what was enforced by the state.

Alabama's preemption powers derive from the state's adherence to Dillon's Rule. In this case, the Alabama Constitution did not explicitly give municipalities the authority to set minimum wages, so the legislature determined the power to raise the wage was not reasonably implied, and quickly overruled the ordinance. Sixty-five thousand low-wage workers, 28,000 of whom identified as Black, were blocked from receiving higher wages (Blair et al., 2020).

ARGUMENTS IN FAVOR OF PREEMPTION: CONSERVATIVE STATES VERSUS LIBERAL CITIES

Despite its controversial use, many legislators favor preemption. The liberal metropolitan areas in Southern states are the exceptions, not the norm, in what are otherwise deep red, conservative territories. The liberal politics of urban areas are often met with enormous opposition by Republican constituents, lobbyists, and legislators, which makes statewide coalition building extremely difficult (Adler, 2016). For example, a number of Southern states enforce "right to work" laws, giving oppressed workers little incentive to organize and risk losing their jobs (Shermer, 2018).

Some states see preemption as a tool for protecting rural areas from the threat of liberal cities. Ebert's (2017) article references Texas Lt. Governor Dan Patrick, who remarked:

> Where do we have all our problems in America? Not at the state level, run by Republicans, but in our cities that are mostly controlled by Democrat mayors and Democrat city councilmen and women. That's where you see liberal policies. That's where you see high taxes. That's where you see street crime. (para. 17)

Others view preemption as a recourse for stopping "left-wing special interest groups" from implementing liberal policies that do not reflect the will of the majority of the state (Ebert, 2017). Less partisan arguments for preemption claim local autonomy will lead to confusing laws and

statutes that will undermine the authority of state governments (DuPuis et al., 2018).

Conservative lawmakers routinely frame progressive worker rights strategies as liberal overreach, but it is abundantly clear that preemption policies passed by legislatures do not hold the best interest of workers at heart nor acknowledge the legislations' disparate racial affect. (K.W., 2017; Graham, 2017). The cases of Birmingham and Nashville make it clear that preemption is not only a way to limit the power of more diverse cities in the South; more seriously, it codifies the oppression of Black workers and limits their access to quality jobs.

WORKERS FIGHT BACK: STRATEGIES TO CIRCUMVENT PREEMPTION

Despite numerous obstacles, advocates and policymakers have made some headway against preemption and found intersectional, contemporary strategies for a contemporary problem. Cohen (2017) pairs traditional worker advocacy with creative techniques to create solutions that challenge contemporary preemption—for example, lobbying, using municipal administrative powers, and legally challenging legislatures.

Cohen (2017) argues that the first and perhaps the most obvious way to challenge legislatures is by lobbying and forming diverse coalitions among cities with the aim of strengthening the power of local municipalities, amending legislation, and asking legislatures to end preemption permanently. For example, "A coalition of grassroots groups in Louisiana have been lobbying state leaders for at least the past five years to lift families out of poverty through an across-the-board wage increase" (Partnership for Working Families, 2019, p. 8). Of course, this strategy seldom yields results in states with "strong red/blue divide or anti-urban animus" like the South (Cohen, 2017, para. 6).

Cities may also take legal action to halt preemption (Cohen, 2017). Avenues for legal recourse include "claiming that a preemption bill discriminates against a protected class, impinges on a fundamental right, or is motivated by animus" (Bean & Strano, 2019, p. 21). After the Alabama Legislature preempted Birmingham's minimum wage ordinance, several fast food workers and local organizations joined a class action lawsuit. The plaintiffs argued that the State's bill "perpetuates Alabama's de jure policy of white supremacy, in particular its suppression of local black majorities through imposition of white control by state government" (Koplowitz, 2019, para. 4). Unfortunately, the Eleventh Circuit Court of Appeals dismissed the case on an improper filing technicality without considering the merits of the argument (Koplowitz, 2019). Cohen (2017) notes that smaller cities and municipalities with fewer resources may consider joining forces with other organizations, cities, and nonprofits when pursuing financially hefty cases against the state.

Finally, Cohen (2017) asserts that in the absence of legislative power, cities must utilize other powers, such as setting a city policy, creating a new program, or using the so-called power of the purse. Although administration actions (much like Executive Orders) can be repealed and are subject to changing administrations and partisanship, Southern cities like Atlanta and Houston have used administrative means to success in circumventing preemption (Cohen, 2017). Atlanta, for example, increased the city employees' minimum wage to $15 an hour over two years by allocating more money to employees' salaries in the city budget, which avoided the state's restrictions on raising municipal wages (Cohen, 2017). To circumvent their Republican legislature's hard-line stance on marijuana legalization, Houston city officials and the county district attorney used their enforcement powers to severely limit the arrest and prosecution of individuals with small amounts of marijuana, "leading to a de facto decriminalization of marijuana" (Cohen, 2017, para. 9; Dart, 2017). In the difficult racial and political context of Southern preemption, this solution may appear most appealing and yield the most success.

CONCLUSION

From Reconstruction to the new millennium, Southern lawmakers have used preemption to oppress Black workers. Dillon's Rule and post-Reconstruction Black Codes laid a firm foundation for contemporary Black worker suppression through preemption. Under the guise of exercising state power over "out-of-control" municipalities, twenty-first century conservative lawmakers continue to strike down any attempt to strengthen worker protections made by more progressive (and often more Black) municipalities (Blair et al., 2020). The Alabama State Legislature prevented the passage of Birmingham's ordinance that raised the minimum wage. In Nashville, residents watched as their amendment to implement local-hire was reversed just a few weeks after its passage.

Although deeply-entrenched white supremacy makes the prospect of any immediate progress seem bleak, worker advocates, legal experts, and nonprofit organizations continue to make headway against preemption. Victories in cities like Atlanta and Houston demonstrate the power of lobbying, administrative action, and legal advocacy, and provide a framework for organizers and community members to continue advancing the rights of Black workers.

The racial, political, economic, and community implications and effects of preemption provide the perfect landscape for social work practice. Though social work is not traditionally linked to the fight for workers' rights, modern-day preemption provides micro-, mezzo- and macro-level advocacy opportunities for practitioners--opportunities that demand comprehensive organizing, advocacy, and legislative solutions.

Before his murder, Dr. Martin Luther King Jr. famously supported Memphis sanitation workers striking for better treatment and wages (Craig, 2018). The day before he was assassinated, King delivered a passionate speech on the topic to the Bishop Charles Mason Temple in Memphis. He said:

> But then the Good Samaritan came by, and he reversed the question: "If I do not stop to help this man, what will happen to him?" That's the question before you tonight. (Yes) Not, "If I stop to help the sanitation workers, what will happen to my job?" Not, "If I stop to help the sanitation workers, what will happen to all of the hours that I usually spend in my office every day and every week as a pastor?" (Yes) The

> question is not, "If I stop to help this man in need, what will happen to me?" The question is, "If I do not stop to help the sanitation workers, what will happen to them?" That's the question. (King, 1968, para. 30)

As we continue the centuries-old struggle for Black liberation and rights, we must recognize that no worker is truly free until Black workers are free. Freedom starts with challenging preemption in the South.

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The Overdiagnosis of Bipolar Disorder Within Marginalized Communities: A Call to Action

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This paper argues that the overdiagnosis of bipolar disorder (BD) is an urgent and underrecognized problem within the U.S., threatening to expose vulnerable Americans to heightened stigma and harmful drug effects while disguising the environmental and traumagenic roots of their distress. The paper traces BD overdiagnosis to biomedical assumptions about mental illness and to the decline of social welfare policies over the past twenty-five years. It calls on policymakers to address BD overdiagnosis by revising criteria in the DSM 5, developing psychosocial models of mental illness, and reintroducing protective social welfare programs. Finally, the paper urges social workers to educate themselves about the harms of BD overdiagnosis as well as to recognize their own role in medicalizing their clients' distress.

THE OVERDIAGNOSIS OF BIPOLAR DISORDER WITHIN MARGINALIZED COMMUNITIES: A CALL TO ACTION

Researchers have been sounding the alarm about the overdiagnosis of bipolar disorder (BD) for more than a decade (Ghouse et al., 2013). For example, in 2008, Goldberg et al. found that only 33% of a cohort diagnosed with BD actually met clinical conditions, and in 2010, Ruggero et al. discovered that 60% of patients studied had been misdiagnosed as having BD. A meta-analysis by Mitchell (2012) reported rampant overdiagnosis of BD driven by flawed screening tools and studies inflating the prevalence of BD. One year later, another literature review found BD misdiagnoses reaching rates of 67% (Ghouse et al., 2013).

The scope of the problem is vast, with some researchers pressing for even greater rates of diagnosis and setting BD prevalence as high as 27% (Mitchell, 2012). While anyone can be subject to misdiagnosis, those who suffer from other mental health conditions, such as major depressive disorder (MDD) and substance use disorder (SUD), are especially at risk (Mitchell, 2012). BD diagnoses are also disproportionately applied to people with limited social support, low socioeconomic status, and a history of traumatic experiences (Fusar-Poli et al., 2017). Given that BD is thought to be a lifelong affliction, the consequences of overdiagnosis extend far into each individual's future.

Some of the most serious consequences of misdiagnosing BD are pharmacological. Lithium, a prescription mood stabilizer medication and first-line treatment for BD, has been shown to increase risks of hypothyroidism and chronic kidney disease (Littrell, 2012; Livingstone & Rampes, 2006; Presne et al., 2003). A 2012 systematic review discovered renal, cardio-vascular, and neurotoxicity in older adults using lithium (Sun, Hermann & Shulman, 2017). Huxley & Baldessarini (2007) report that lithium's neurotoxic effects can lead to greater impairment and disability among those diagnosed with BD, such as memory loss and decreased executive functioning. Severe risks associated with antipsychotics, another common treatment for BD, include cardiovascular disease, osteoporosis, and significant reductions in brain tissue over time (Voineskos et al., 2020; Littrell, 2012; Dorph-Petersen et al., 2005).

Another harmful consequence of BD overdiagnosis is the risk of exposure to social and internalized stigma, which can lead to social exclusion, occupational failure, and reduced functioning (Hawke et al., 2013). Researchers suggest that the stigma imparted by BD diagnosis, similar to that of schizophrenia, may reflect the condition's longevity and genetic roots (Hawke et al., 2013). Unfortunately, the harms of BD stigma appear to be highest for those most at risk of misdiagnosis: those who lack support systems and carry stigma brought on by other diagnoses (Fusar-Poli et al., 2017).

Perhaps the most insidious result of inflating BD diagnoses, and the one which may be of most concern to social workers, is the masking of oppressive social conditions. Like all disorders involving psychosis, BD and its symptoms have been linked to childhood abuse, perceived stress, and poor physical health, all of which disproportionately affect poor communities and communities of color (Fusar-Poli et al., 2017). Environmental stressors including poverty, crime, and racial discrimination are correlated with depressive symptoms, psychosis, and the dysregulation of the limbic system; research suggests that they may also be erroneously attributed to BD (Cogan et al., 2020; Gómez, 2015; Jackson et al., 2010). As a result, there are serious concerns that the rise in BD diagnoses, with their biological underpinnings, is concealing increasing social and environmental distress among marginalized Americans.

POLICY RESPONSE

According to critics, the biggest drivers of BD overdiagnosis are its diagnostic criteria and estimates of prevalence, both of which have shifted dramatically over the past three decades (Ghouse et al., 2013; Mitchell, 2012; Littrell, 2012; Burrows, 2010). In 1994, the DSM IV introduced bipolar II by expanding mania, the central feature of bipolar I disorder, into the less severe category of hypomania, despite mania's high concordance and limited evidence for its expansion (Yutzy et al., 2013; Singerman et al., 1981). Following the introduction of bipolar II, a small group of researchers developed the idea of "subthreshold" or "subclinical" BD, which further expanded criteria and prevalence estimates (Mitchell, 2012). Between 1994 and 2007, BD diagnoses doubled in adults and multiplied by 40 in children, while estimates of BD's prevalence rose from 1.6% to 24.2% of the population (Burrows, 2010; National Institute of Mental Health, 2007).

Critics regard the DSM IV's changes to BD's nosology as arbitrary and unsupported by evidence (Yutzy et al., 2013; Mitchell, 2012). They reject that surges in BD diagnoses capture an increasing incidence of the disorder, which, given BD's biogenetic roots, should remain stable over time (Almeida et al., 2020). Instead, these researchers argue that BD's expanded diagnostic criteria and inflated prevalence estimates have led to an epidemic of overdiagnosis (Ghouse et al., 2013; Mitchell, 2012).

Despite these criticisms and growing evidence of overdiagnosis, researchers and policymakers have done little to address the problem. In 2013, the newly released DSM 5 rebuffed warnings of overdiagnosis by expanding subsyndromal criteria for BD, a change that may significantly increase the risk of depressive patients being misdiagnosed with BD (Carta & Angst, 2016; Cerimele et al., 2014). Other issues related to BD's overdiagnosis, such as diagnostic overlap with schizophrenia, schizoaffective and borderline personality disorders, comorbidity with anxiety and unipolar depression, and reliance on overly sensitive screening instruments were not addressed within the DSM 5, even though they were well-documented at the time of its publication (Cosgrove & Suppes, 2013; Mitchell, 2012; Vieta & Philips, 2007).

Of the factors contributing to BD overdiagnosis, one of the most serious is the DSM 5's failure to clarify the relationship between BD and post-traumatic stress disorder (PTSD). The co-incidence of PTSD in BD patients has been cited at 35%; the two disorders share multiple symptoms and affect similar regions of the brain (Carmassi et al., 2020; McCormack & Thompson, 2017; Rakofsky et al., 2011). Despite calls from some researchers, the need to screen and control for trauma disorders in potential BD patients has been ignored, leaving marginalized communities, who experience disproportionate rates of trauma and decreased access to trauma-informed care, at risk of misdiagnosis (Etaine et al., 2008). Evidence suggests that misdiagnoses of BD leave trauma survivors less likely to receive appropriate care, with BD patients on Medicaid being offered less therapy and more unsupervised drug treatments than other patients (Busch et al., 2007; Fontanella et al., 2015).

UNDERLYING ASSUMPTIONS

Diagnostic psychology has been slow to recognize the problem of BD overdiagnosis in part due to its underlying assumptions about individuals with BD. One such assumption is that BD and its symptoms are biogenetic in origin. This claim is supported by family studies of bipolar I, but has not been substantiated for the diagnostic labels critics believe are driving overdiagnosis: bipolar II and subclinical BD (or "bipolar not otherwise specified") (Almeida et al., 2020; Mitchell, 2012). In fact, inconclusive findings have led some researchers to question whether bipolar I and bipolar II are genetically related conditions (Littrell, 2012). Despite this lack of evidence and a wealth of literature identifying BD symptoms with over 51 unique environmental stressors, diagnostic psychology continues to regard bipolar II and sub-clinical BD as biogenetic disorders (Bortolato et al., 2017).

Another assumption obscuring BD overdiagnosis is that people diagnosed with BD have little hope of recovery. Once again, evidence of poor prognosis is significant for bipolar I but is less clear for bipolar II and subclinical BD, both of which have garnered less research (Almeida et al., 2020). One historically important variable in determining BD's prognosis is unemployment, which involves social factors as much as it reflects individual impairment. For instance, data showing that around 57-65% of BD patients were unemployed in 2007 compared to only 15% in the 1970s is difficult to explain without recourse to other factors, such as deindustrialization and declining job security (Huxley & Baldessarini, 2007). Indeed, opponents of overdiagnosis argue that social distress due to rising work insecurity has been systematically mislabeled as mental illness over the past four decades, disguising the problem and worsening outcomes (Buffel et al., 2017; Wong, 2016).

A third assumption about those diagnosed with BD is that their condition is universal and "colorblind." In light of this assumption, some researchers have taken the low prevalence of BD among Black Americans as a sign of underdiagnosis, dismissing findings that the prevalence of mood disorders is consistently lower in Black communities than in white communities (Alvarez et al., 2018; Boyd et al., 2011; Breslau et al., 2008; Neighbors et al., 2003; Woodward et al., 2011). Calls for increased screening among Black Americans carry a notable threat of overdiagnosis, given that actual prevalence appears to be low, and the depressive and trauma-related symptoms associated with anti-Black oppression are frequently mislabelled as mental illness (Jarvis, 2007; Stevenson et al., 1997). Meanwhile, the DSM's colorblind approach to mental health treatment, which has failed to account for how psychological diagnoses impact racial groups differently, means that the risks of BD overdiagnosis within communities of color have not been monitored by mental health policymakers (Green et al., 2012).

While these assumptions have all likely contributed to the failure to address BD overdiagnosis, diagnostic psychology's neglect of social and environmental problems is rooted in its assumption that mental illness represents discrete, biologically based diseases, a claim unsupported by evidence despite over 40 years of influence (Jacob et al., 2014; Timimi, 2014). Critics of the "bio-medicalization" of mental health, stemming from the publication of the DSM III in 1980, complain that it has led to "tunnel vision" about mental illness, even as evidence has increasingly characterized mental illness not as distinct clusters of biogenetic symptoms, but as transdiagnostic distress linked to trauma, deprivation, and social inequality (Pilgrim, 2014; Rimke, 2016; Timimi, 2014).

One explanation for the persistence of the biomedical model of mental illness, despite a lack of evidence to support it, is its shared assumptions with neoliberalism, which holds that individuals are responsible for their own health, have equal agency, and resolve their needs and problems through the consumption of private goods (Rimke, 2016). Detractors argue that neoliberal assumptions about mental distress have pathologized poor and minority groups, who have limited agency to address their problems, and have helped medicalize social welfare, with government support becoming increasingly contingent on diagnoses of physical and mental disability (Wong, 2016). From this perspective, the medicalization of social welfare and the overdiagnosis of mental illness are mutually reinforcing, expressing the same neoliberal logic of privatization and growth that has dominated U.S. policy since the 1980s (Rimke, 2016).

OVERDIAGNOSIS AND WELFARE REFORM

While few, if any, peer-reviewed studies have explored the relationship between social welfare reform and the overdiagnosis of BD, evidence suggests that the two are closely related. Following the 1996 Personal Responsibility and Work Opportunity Act's (PRWORA) dismantling of traditional welfare, BD diagnoses skyrocketed, along with enrollment in supplemental security income (SSI), which rose fourfold between 1996 and 1998 (Burrows, 2010; Jans et al., 2004). As impoverished Americans flocked to SSI as a source of financial stability and Medicaid access, mood disorders became the largest and fastest-growing drivers of enrollment, with a 100% increase in children applying to SSI and Medicaid under BD diagnoses between 2001 to 2010 (National Academies of Science, Engineering & Medicine et al., 2015; Drake et al., 2013).

Findings of rampant BD overdiagnosis among SSI recipients indicate that these surges in SSI enrollment reflect welfare-related needs rather than shifts in BD's true prevalence (Ghouse et al., 2013). Multiple studies have connected rising BD diagnoses to gaps in post-welfare services. For example, a 2006 study found that impoverished Americans were pursuing BD diagnoses in order to receive substance-related treatment, which the PRWORA purged from coverage in 1996 (Stein et al., 2006). Meanwhile, multinational studies on the medicalization of unemployment suggest that increasing rates of joblessness among SSI recipients with BD diagnoses reflect unmet needs for stable employment, with many frustrated SSI enrollees expressing a desire to work (Buffel et al., 2017; Frank, 2013; Holmqvist, 2009).

As with most neoliberal policies, the PRWORA's transfer of poverty services from welfare to disability programs has benefitted private interests, including pharmaceutical companies and a growing industry of mental health professionals, all of which reap profits from psychiatric overdiagnosis, expanded categories of mental illness, and reallocations of government spending (Mitchell, 2012; Rimke, 2016). Vulnerable Americans, including those applying for disability under misapplied BD diagnoses, suffer the greatest losses as unmet needs for employment, housing support, healthcare access, neighborhood investment, and anti-discrimination policies are met with irrelevant and often harmful mental health interventions (Shepherd & Wilson, 2018; Rimke, 2016; Mills, 2015; Hansen et al., 2014).

ADVOCACY ORGANIZATIONS

According to prominent psychiatrist and DSM 5 critic Allen J. Frances, American mental health advocacy groups have consistently failed to push back against the overdiagnosis of psychiatric disorders (Frances, 2010). Instead, advocacy groups such as the American Psychological Association (APA), the National Alliance of Mental Illness (NAMI), and the National Association of Social Workers (NASW) have issued demands for heightened mental health screenings within marginalized communities, calls which have drawn frequent support from the pharmaceutical lobby (American Psychiatric Association, 2015; Davis & Williams, 2020; Frances, 2010). These campaigns, which express the influence and assumptions of America's powerful mental health industry, reflect that there are currently few, if any, advocacy groups addressing the problem of BD overdiagnosis within the U.S. The majority of organizations recognizing overdiagnosis now operate in other countries.

One of the most influential of these organizations is Mental Health Europe (MHE), a pan-European, non-governmental organization (NGO), which has pushed for a demedicalized, psychosocial approach to mental health policy over the past decade. In 2012, MHE set up a task force to investigate the development of the DSM 5, releasing a statement that denounced its biomedical assumptions, expanded diagnoses, and promotion of "unnecessary and harmful" drug treatments (Mental Health Europe, 2014; Mental Health Europe, 2013). In a follow-up report, MHE called on the European Union and World Health Organization to ignore expanded DSM diagnoses unsupported by evidence, to offer diagnostic alternatives, and to cease promoting psychiatric medications as a first line response to distress (Mental Health Europe, 2015). MHE's criticisms of the DSM 5 have been influential across Europe, with the Superior Health Council of Belgium declaring in 2019 that the DSM would no longer be at the nation's "center of [mental health]care planning" (Simons, 2019).

In addition to curtailing the influence of the DSM 5, MHE has targeted several other drivers of psychiatric overdiagnosis. Since 2013, MHE has called for legislation to expose the financial ties between mental health policymakers, professional organizations, and pharmaceutical companies (L'Ecluse, 2019). MHE has also launched an investigation into the influence of chronic unemployment on rising "psychosocial disability," a term MHE uses in place of mental illness (Mental Health Europe, 2016). MHE's proposal of work programs for those labeled mentally ill was approved by the Council of the European Union in 2016, suggesting that Europe is moving away from the medicalization of unemployment, as well as from biogenetic models of mental illness in which disability is considered incurable (Finn, 2017; Mental Health Europe, 2016). Meanwhile, the ascendency of MHE's psychosocial approach to mental health was powerfully expressed in a 2017 report from the United Nation General Assembly, which declared that the "neurological paradigm [of mental illness] causes more harm than good," and called for a shift "from focusing on chemical imbalances to focusing on power imbalances and inequalities" (Kinderman, 2020).

A CALL TO ACTION: POLICY AND PRACTICE

To address BD overdiagnosis within the U.S., policymakers must first study the hundreds of thousands of Americans receiving SSI benefits under BD diagnoses, a growing population at high risk of childhood trauma, poverty, and homelessness (Cerimele et al., 2014; Etain et al., 2008; Huxley & Baldessarini, 2007). New and focused research is needed to determine if these are in fact "risk factors" for BD, as is usually assumed, or if they are generating transdiagnostic symptoms which are driving overdiagnosis. There is also an urgent need for studies exploring the socioeconomic deprivation behind BD diagnoses, and the extent to which underemployment and poor access to healthcare are motivating Americans to seek SSI enrollment (Ghouse et al., 2013; Wong, 2016). Finally, researchers need to examine the impact of BD diagnoses within communities of color and the intersections of racial stigma with those brought on by DSM diagnoses and disability status (Hawke et al., 2013).

As researchers develop a clearer image of BD overdiagnosis, the mental health community can begin taking steps to address it. One strategy is to demand that researchers stop using inflated figures to characterize BD and instead adhere to conventional, evidence-based estimates of BD's prevalence, which have ranged from 1% to 2% of the population (Mitchell, 2012). Another step is to discourage or eliminate the use of screening tools like the Mood Disorder Questionnaire (MDQ) and return to clinical interviews as the "gold standard" in BD diagnosis (Ghouse et al., 2013). The most direct path to reducing overdiagnosis is to revise expanded criteria for BD by removing the "bipolar not otherwise specified" category from the DSM 5, and by toughening criteria surrounding hypomanic episodes, the key symptom in bipolar II (Mitchell, 2012). Some researchers, citing findings that bipolar II has no clear genetic profile and is not phenotypically distinctive from unipolar depression, have explored eliminating the bipolar II diagnosis altogether, which would lead to substantially fewer diagnoses of BD (Gitlin & Malhi, 2020; Parker & Fletcher, 2009).

Others insist that addressing the roots of BD overdiagnosis will require more dramatic changes to the DSM. BD's high comorbidity, expanding criteria and subtypes, and failure to control for environmental distress point to a broader crisis in post-DSM III psychiatry, which has failed to successfully classify mental illness into distinct conditions, find biogenetic markers for core diagnoses, or curtail its own expansion (Ghaemi, 2014; Timimi, 2014). Thus, stemming the flow of overdiagnosis may require the diagnostic system established with the DSM III, which has consistently prized reliability over external validity, to be abandoned (Dutta et al., 2007; Pilgrim, 2014; Vieta & Philips, 2007). In its place, researchers propose the DSM be reorganized into a dimensional system with less arbitrary divisions between symptoms and fewer pathologizing diagnoses (Dutta et al., 2007; Vieta & Philips, 2007). Others demand that the DSM adopt a "traumagenic" model of mental illness that is based on shared experiences of adversity and encourages environmental over drug-focused interventions (Pilgrim, 2014).

MHE's campaign for financial transparency and protective social policies provides a potential blueprint for curbing psychiatric overdiagnosis within the U.S. Legislation preventing researchers with drug industry ties from serving on DSM panels could reduce pressures to further widen diagnostic criteria, while housing and employment programs for those at risk of being labelled mentally ill would likely lead to fewer diagnoses and less biogenetic pessimism about mental illness (Elinson et al., 2007; Huxley & Baldessarini, 2007). By following Belgium's lead and decentering the DSM within its healthcare system, the U.S. could begin to explore diagnostic models that are more sensitive to the social, economic and racial determinants of mental health. Finally, retiring the stigmatizing term "mental illness," which locates the roots of mental distress within dysfunctional individuals, may help cleanse U.S. mental healthcare of neoliberal assumptions that are driving overdiagnosis and the privatization of poverty (Mills, 2015; Rimke, 2016; Shepherd & Wilson, 2018).

Social workers will need to think critically about how to respond to the problem of BD overdiagnosis, both as clinicians and as advocates for change. As clinicians, social workers need to familiarize themselves with the harms that BD diagnoses can impose on clients, such as heightened stigma, adverse drug effects, and enrollment in disability programs that can further reduce functioning (Hawke et al., 2013; Huxley & Baldessarini, 2007; Littrell, 2012). Similarly, social workers should be aware of the pressures they face to apply DSM diagnoses, including organizational needs for efficiency, growth, and specialization, directives which often benefit social workers and their status as health professionals (Rimke, 2016). Finally, clinical social workers need to look beyond biological theories and identify the environmental factors driving clients to seek BD diagnoses, such as childhood trauma, housing instability, underemployment, and a lack of welfare related services. They must bear in mind that a BD diagnosis is a mark of lifelong biogenetic dysfunction, one that may render clients less likely to receive the help that they need.

As advocates, social workers must challenge calls to reduce mental health disparities through indiscriminate screening and warn policymakers about the differential impact of BD overdiagnosis within minority communities. They must resist the increasing bio-medicalization of mental health and be prepared to defy a system of diagnostic psychology which many researchers say has lost its claim to scientific validity (Dutta et al., 2007; Ghaemi, 2014; Jacob et al., 2014; Pilgrim, 2014; Timimi, 2014). Finally, social workers will need to join researchers in psychiatry and psychology to develop new systems of diagnoses that link mental distress to environmental risk factors and harmful public policies (Rimke, 2016). Social workers will need to decide for themselves whether a public conception of mental health is possible within the U.S.'s privatized healthcare system, and within an unregulated market economy that prioritizes innovation and profits over social protections.

Whatever they decide, social workers can no longer afford to ignore the overdiagnosis of BD, which has mischaracterized distress, bolstered stigmas, and placed the burden of change on those who are often least able to effect it.

CONCLUSION

BD overdiagnosis is a growing problem within the U.S., especially among marginalized Americans seeking social support through SSI enrollment. Consequences of misdiagnosis include heightened stigma, adverse drug effects, and the concealment of environmental distress within poor communities and communities of color. A new frontline in the medicalization of poverty, the overdiagnosis of BD has been poorly monitored by mental health organizations, which have launched uncritical campaigns for increased mental health screening amidst widespread reports of invalid diagnoses (American Psychiatric Association, 2015).

BD overdiagnosis is perpetuated by clinical assumptions that BD is undertreated, prone to subclinical presentations and underrecognized in communities of color, claims which have failed to amass significant evidence (Littrell, 2012; Mitchell, 2012). Assumptions about BD's poor prognosis and biogenetic origins are rooted in the unsubstantiated claim that mental illness involves discrete biologically based conditions, and from neoliberal assumptions about the sources of and solutions to mental distress, which have helped to medicalize and dismantle social welfare programs over the past four decades (Timimi, 2014; Wong, 2016). Policymakers are encouraged to follow Mental Health Europe's example by passing financial transparency laws, decentering the DSM within mental healthcare, and introducing protective social programs that offer employment, stable housing, and expanded access to healthcare. Recommendations targeting BD overdiagnosis include narrowing diagnostic criteria in the DSM 5 and developing new traumagenic models of mental distress that are sensitive to social inequalities. Social workers are called to educate themselves about the harms of BD overdiagnosis, to press for a psychosocial and welfare-based approach to mental healthcare, and to maintain a healthy skepticism about DSM diagnoses and their status as evidence-based guides to practice.

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The *Testimonios* of System-Impacted Daughters of Color on Healing from Parental Incarceration

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1 in every 25 children in the United States currently has a parent incarcerated in jail or prison. Black and Latinx children make up the majority of this population, as their parents are overrepresented in local jails and state and federal prisons. Parental incarceration affects a child's behavior, emotional and mental health, social interaction, and financial stability. Daughters of incarcerated parents are particularly affected. This research investigates *testimonios* (testimonies), a narrative form of counter-storytelling, as a tool to address the traumatic effect of parental incarceration on female children of color. *Testimonios* give a person agency and allow them to share their unique and nuanced experiences in detail. In-depth interviews demonstrated that *testimonios* can be an effective healing tool for women who have been impacted by parental incarceration and can improve social service organizations directed towards families affected by incarceration. *Testimonios* provided space in which daughters of incarcerated parents were able to express their emotions and make sense of their experiences. The interviews also revealed shared themes in the experiences of multiple interviewees.

THE *TESTIMONIOS* OF SYSTEM-IMPACTED DAUGHTERS OF COLOR ON HEALING FROM PARENTAL INCARCERATION

BACKGROUND

Despite having 5% of the world's population, the United States currently holds over 25% of the world's incarcerated population, with 2.3 million people currently in jail or prison (American Civil Liberties Union [ACLU], 2020). Data shows that 52-63% of individuals who are incarcerated have children, with the number of mothers rapidly increasing in recent years (Thomson et al., 2018). Nationwide, one in every 25 children currently has a parent incarcerated in jail or prison, and an estimated five to eight million children have experienced parental incarceration in their lifetime (Haskin & Turney, 2018). Parental incarceration affects entire families, but children experience higher instances of trauma and adversity as a result of parental incarceration (Arditti & Savla, 2015).

Children who have experienced the incarceration of a parent, family member, or community member are often referred to as being "system-impacted" (Cerda-Jara et al., 2019, p. 2). In this paper, "system-impacted" specifically refers to a child's experience of parental incarceration. This research focuses on female system-impacted children, referred to as daughters, because previous literature has demonstrated that daughters experience higher instances of antisocial behavior, anger, impulsivity, low self-esteem, and delinquency than sons as a result of parental incarceration (Burgess-Proctor et al., 2016). This research also focuses on system-impacted daughters of color because Black and Latinx parents are disproportionately represented in state and federal prison populations. For example, Black people make up 13% of the U.S. population, but 40% of the incarcerated population (Sawyer & Wagner, 2020). These numbers are a reflection of the disproportionate incarceration rates for the Black and Latinx populations (Western & Pettit, 2010).

Current literature has found that parental incarceration has both short- and long-term negative effects on children (Miller, 2006). In the short term, system-impacted children experience traumatic separation, loneliness, unstable childcare arrangements, and the effects of reduced family income (Murray et al, 2012). In the long term, system-impacted children are at higher risk of experiencing intergenerational incarceration, antisocial behavior, stigmatization, poor educational performance, and stress (Murrey, 2015), as well as general anger and additional mental health problems (Wakefield, 2007).

Existing research, largely based on quantitative analyses, fails to capture the voices of system-impacted children and the nuances of their unique experiences with parental incarceration. Academics have too often lumped all system-impacted children together when researching their experiences. For example, Burgess-Proctor et al. (2016) studied the effects of parental incarceration on both daughters and sons, but failed to analyze the impact of race and ethnicity on the lived experiences of both genders. It is important that an intersectional lens is applied to fully capture experiences of children with incarcerated parents. *Testimonios* are intended to capture the intersectional and nuanced experiences of system-impacted children with regard to gender, race, ethnicity, socioeconomic status, and so forth.

RESEARCH QUESTIONS

This paper focuses on the traumatic effects of parental incarceration on daughters of color and demonstrates how *testimonios*, a form of counter-storytelling, can be used as an effective healing tool. Conversations around parental incarceration are limited due to immense stigma and shame. Family members often tell children that their incarcerated parent is on vacation, rather than in jail or prison; however, children discover their parent's incarceration through other social means, such as friends (Burgess-Proctor et al., 2016). When children are told about the incarceration, they often proceed to conceal their parent's incarceration from friends and others (Burgess-Proctor et al., 2016) due to the stigmatization that will follow them into adulthood (Sykes & Pettit, 2014). To counter the stigma and shame around parental incarceration, this research shed light on the following research questions:

1. How have daughters of color with incarcerated parents expressed themselves through storytelling?
2. Can counter-storytelling be used as an effective healing tool for daughters who have experienced parental incarceration?

Counter-storytelling is a framework used to elevate the voices of populations who are often forgotten and long silenced, making it an ideal method for addressing the needs of system-impacted daughters of color (Yosso, 2013). Counter-storytelling occurs when a person tells their life story or shares a particular experience, either informally in a conversation with another person or formally as a culturally responsive tool in a therapeutic setting. It has been found to be an effective tool for healing after trauma. For example, Native Americans who experienced forced boarding school reported emotional release and healing when sharing their stories through counter-storytelling (Charbonneau-Dahlen et al., 2016). Counter-storytelling promotes resiliency by showcasing how a person has adapted and built skills in order to overcome the systemic barriers and oppression they have faced (Hess, 2019). For instance, in response to an environment where there was an absence of nurturing roles in boarding schools, Native American fifth and sixth graders developed survival skills by becoming caregivers themselves for younger children. Most important, counter-storytelling shifts and challenges the white supremicist paradigm by illuminating patterns of racialized inequality through recounting experiences of individualized and shared racism (Yosso, 2013).

In this paper, Critical Race Theory (CRT) will be used in conjunction with counter-storytelling to elevate the voices of marginalized, underserved, and silenced system-impacted daughters of color. CRT is a theoretical framework used in the social sciences that examines the relationship between society and race, law, and power (Crenshaw et al., 1995). Using this framework will provide an in-depth look at how race and power impact populations who experience parental incarceration. CRT and counter-storytelling have been used in a variety of situations to help individuals heal from trauma and have been shown to acknowledge the resilience and survival skills of marginalized populations (Solorzano & Yosso, 2001). CRT is important for this research because most children who experience parental incarceration are people of color, creating an increase in future class and racial inequality through the negative consequences of mass incarceration on children (Wildeman & Western, 2010).

Testimonios are used strategically to give agency to daughters of color. Agency gives people the power to negotiate their needs and identify what they feel in spaces of inequality (Cushing & Lewis, 2009). This form of storytelling has been used in feminist research methodologies as a form of resistance, a tool for resilience building, and a source of hope in the midst of challenging systemic oppression (Huber & Cueva, 2012). *Testimonios* decolonize storytelling by giving a person agency to highlight power and oppression, and can be viewed as a genre within counter-storytelling (Medina, 2018.).

METHODOLOGY

Previous research on the experiences of system-impacted children has reduced their experiences to statistics using quantitative methods. As such, through the practice of counter-storytelling with a CRT lens, this research provides a more in-depth representation of the experiences of system-impacted daughters of color. The qualitative data comes from in-depth interviews with two women who had incarcerated parents and one employee from Homeboy Industries' Legal Services department who had worked with the interviewees for over a year. Homeboy Industries, based in Los Angeles, CA, is a nonprofit organization that assists former gang members, previously incarcerated individuals, and their families to become positive contributing members of society through providing access to job placements, tattoo removals, therapy, and legal services (Leap et al., 2011). The organization is considered a good fit for this research because of their work with system-impacted families.

The women interviewed were from Los Angeles, CA, Mexican-American, in their late twenties, and both experienced the incarceration of their fathers when they were adolescents. Respondents were asked 18 questions during the interview about how they navigated their parent's incarceration, communicated with others, and what resources they deem necessary for healing. The interview questions include: "Looking back, how would you say being system-impacted affected your trajectory?"; "As of today, do you share your narrative of being system-impacted with others?"; "How do you feel when you talk about your mother's/father's incarceration?"; and "What services do you feel are necessary for daughters to heal from parental incarceration?" The employee interviewed was asked different questions, such as, "In your role, do you experience listening to the children's narratives/stories about their experience with parental incarceration?" These questions were constructed ahead of the interview and were open-ended to promote discussion. Additional probing questions were asked during each interview when a respondent disclosed new information. For example, when an interviewee disclosed the impact her father's incarceration had on her career choice, she was asked to elaborate. Interviews were conducted in the Homeboy Industries legal office and recorded using a phone device and deleted soon after the interview was transcribed by the researcher.

All respondents were given consent forms and informed about the study's objective beforehand. Ethical measures were taken throughout the duration of the research project and pseudonyms are assigned to each respondent to maintain confidentiality. Before the interviews, the researcher built rapport with each interviewee through legal assistance and everyday interactions at Homeboy Industries. Furthermore, Columbia University Institutional Review Board (IRB) approved this research. The data from the semi-structured interviews were thematically transcribed and analyzed. Google Drive, Google Docs, and Microsoft Excel were used for coding and tracking emerging themes. After the data collection, thematic analysis was used to identify themes and patterns in responses.

RESULTS

The objectives of using *testimonios* are to showcase the point of view of the person being interviewed, identify what they deem important from their experiences, and make an urgent call to action based on the themes and patterns that emerge from their intentional sharing (Reyes & Rodirguez, 2012). Themes that arose across the interviews conducted in this study included a strong sense of healing from sharing *testimonios*, increased willingness to share, education as an escape, financial instability, and negative feelings towards individuals who did not share their struggle. In general, daughters of incarcerated parents found that telling stories of their lived experiences was a form of empowerment.

INTERVIEW RESULTS

STRONG SENSE OF HEALING

The Homeboy Industries' staff person who was interviewed reported observing a strong sense of healing from the women who shared their *testimonios*. Maria and Gabriela, who shared their *testimonios*, agreed and reported that sharing their narratives about their parent's incarceration with others was healing and therapeutic. A staff member who works in Homeboy Industries' Legal Services department focusing on family reunification, expungement, and other court services, stated:

> [They share] all the little details that are important to them and half the time they end up crying. It is more like a therapy session. I only end up using half of...the stuff they have already told me. Half of it is not important to the case...but it is important for me to understand where they are coming from, so I can sort of better craft those declarations for a judge that is going to read. Yeah, a lot of times them doing their legal work ends up sort of being therapeutic sessions because they get to talk to someone who is not going to judge them, who is actually doing something to help them.

The themes in the interview reveal that storytelling and full disclosure about the traumatic experience of having a parent incarcerated can be therapeutic because the speaker is given a chance to share their own experiences and emotions regarding what occurred during this vulnerable part of their lives. The legal services staff stated that when women who are impacted by the criminal justice system are given the opportunity to speak about their experiences, they find it to be therapeutic and healing, especially because they are met with no judgement. For storytelling to work as an effective strategy, the speaker must have an attentive and encouraging listener (Rosenthal, 2003). Therefore, the professional staff at Homeboy Industries fulfilled this role by creating a judgment-free environment for her participants.

AVOIDANCE BY PROFESSIONAL STAFF

Avoidance has been observed in research on parental incarceration (McGinley & Jones, 2018), as well as in this research. The employee interviewed discussed the prevalence of avoidance, or the staff member's reticence to speak of the client's parental incarceration unless they first broached the topic. When asked if she discusses with the children their experiences and feelings about having an incarcerated parent, the staff member responded, "Me no. Because the kids I usually see are five or under so they do not really understand what's going on. They will think their parents were on vacation or somewhere doing a work thing."

The professional staff usually avoids mentioning the incarceration of the children's parents, allowing the children to think that their parents are away on business or vacation. This is a relatively common experience for children as their parents, teachers, and service providers shield the child from the truth of what is really happening with their parents (Burgess-Proctor et al., 2016). This is often due to the parent's shame and guilt of being incarcerated and not wanting to inflict it on their children or not knowing how to address the topic in a way that is understandable for children. However, it is important for these children to grow up and begin to ask questions about their parents. Counter-storytelling can prove beneficial for this population as it speaks directly to these issues and gives voice to them, instead of perpetuating avoidance and secrecy.

EDUCATION

Within all three interviews, education was identified as a form of healing by both staff and the daughters. When asked what is necessary for system-impacted daughters to heal, Maria stated, "I would say education. Something they can be in control of [like] college degrees." She explained that by giving girls who are dealing with their parent's incarceration something they can control, like education, they begin to feel liberated. She recalled, "I would just be at the library, reading books, or learning stuff at school. It would take me to another place, a place where you don't need money."

LONG-TERM FINANCIAL INSTABILITY

Financial instability was another common theme. Both participants shared how their parent's incarceration led to a loss of family income and an increase in financial stress. It is important to acknowledge that in addition to the economic insecurity that exists while a parent is in prison, financial instability continues beyond release. The negative consequences of having a parent incarcerated do not disappear once they return home. Gabriela, who experienced her father's incarceration in middle and high school, reflected on her dad's experience after release: "He did not have a job for five years after that. So my mom was struggling for a long time. I feel like my dad's financial instability affected my mom and our household. So I could not go to college right after high school." Gabriela's father's unemployment and inability to contribute to the family's income affected her educational trajectory by limiting her ability to seek higher education. Both Maria and Gabriela mentioned struggling with food insecurity and paying bills, as well as needing additional assistance while their parents were incarcerated and in the years following.

PRIVILEGE

Another theme that emerged was anger that the daughters had towards others whom they identified as having "privilege," or those who they saw as not having any "real" problems. Through time, however, the anger transformed into a motivation to excel. Maria expressed, "At first, it made me a bit bitter because I would see people who do not have any real problems in life… but I grew out of that." She later explained that her bitterness about her parent's incarceration turned into motivation and increased her personal resilience. The concept of resilience appeared in both of the interviews, when Maria and Gabriela discussed how they came to understand and accept their parent's incarceration and use their adversity as motivation. Previous research has shown that children who experience separation and poverty due to a parent's incarceration experience lasting negative effects. However, through the use of external resources and strength-based factors, children can showcase resiliency (Miller, 2007). Resilience and healing may arise from the practice of storytelling.

BENEFITS OF *TESTIMONIOS*

By sharing their narratives, Maria and Gabriela were able to open up about what they felt when having to deal with their incarcerated parents. Although there were only two interviews with system-impacted daughters and one staff interview conducted, the data supported the predicted hypotheses. *Testimonios* are therapeutic for children of incarcerated parents, allow for a nuanced understanding of their experiences, and provide insight for service providers about the specific needs of the people they serve.

LIMITATIONS

One of the limitations of this research was limited time. Data collection was limited to less than ten weeks. There was not enough time to recruit a larger sample size of participants and it was difficult to create a strong bond with the participants in such a short period of time. Another limitation was the structure and sensibility of the interview. The interview was recorded on a device, creating an environment where interviewees felt reluctant about the amount of information they shared and skepticism about their privacy. A further limitation is that this research was conducted independently without team support.

FUTURE DIRECTIONS

This research highlighted the positive impacts of daughters of color sharing their *testimonios*. Because testimonio sharing was shown to be a source of empowerment, this research demonstrates a need for more safe spaces where daughters of color can feel comfortable sharing their *testimonios*, and in doing so, address their needs and emotions. Safe spaces can include a support group or an after-school program where youth with similar experiences of parental incarceration can get to know each other and feel less alone. These spaces can also provide an outlet for system-impacted children to understand their emotions and process the complexity of their anger. Social services organizations and social work practitioners should strive to create educational programs and support groups for system-impacted children of color.

Through the themes revealed in the interviews, this research points towards the specific needs of system-impacted daughters of color, including financial and educational resources. Without financial support of incarcerated parents, system-impacted children should have rental assistance, food pantries, and educational school supplies available. It is essential to create educational programs that serve this population, as those who experienced parental incarceration have demonstrated that they could be a potential escape. Given the findings of this research, future research with a larger sample size that includes women from other marginalized populations, in particular Black women, is needed to argue the effectiveness of storytelling in healing from parental incarceration.

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Time Doesn't Heal All Wounds: A Call to End Mandated Reporting Laws

G INGUANTA, THEY/THEM
CATHARINE SCIOLLA, SHE/HER

Mandated reporting laws are pertinent to practitioners of "helping professions," such as social workers, doctors, nurses, and teachers. These laws dictate that a professional or student in those fields must report suspected child maltreatment to the state for investigation. The report, as well as the investigation that follows, has the potential to result in removal and separation of children from their parents or caretakers. The child welfare system of which mandated reporting is a component has a cruel history of racism and white supremacy, as well as prejudice towards those experiencing poverty, disabilities, mental health concerns, homelessness, and substance use disorders. This research examines the disproportionate harm the child welfare system has on Black and Brown individuals, particularly in New York, and how the system has used mandated reporting laws to further marginalize oppressed communities since the 1970s. This research indicates the need to comprehensively reimagine the erroneously named "child welfare system" starting with repealing mandated reporting laws in the United States.

TIME DOESN'T HEAL ALL WOUNDS: A CALL TO END MANDATED REPORTING LAWS

LITERATURE REVIEW

THE FOUNDATIONS OF AMERICA'S MODERN FAMILY REGULATION SYSTEM

Historically, the "family regulation system," a term coined by Dorothy Roberts in 2020 for the industry more commonly known as the child welfare system[1], dates back to the 1850s, informally starting with what is known as the Orphan Train movement. Between 1854 and 1929, thousands of poor children from urban settings were kidnapped,[2] and they were moved across the country to be housed with white, Anglo-Saxon protestant parents (Orphan Train, 2020). Even though the work of the Orphan Train movement was reformed through social welfare policy within the United States later on with legislation like the Child Abuse Prevention and Treatment Act (CAPTA), the destruction of families and removal of children from homes has long been a tradition in the United States. White saviorism[3] and paternalism are the backbone of the family regulation system, whose foundational pillars also include the forced sterilization of Black, Indigenous, People of Color (BIPOC) women and folks with disabilities, as well as eugenics (Sterilization and Social Justice Lab [SSJL]). This is the enduring legacy of our modern system: building blocks rooted in paternalism and white supremacy.

The mentality of the Orphan Train movement of the 1850s was to "clean up" the streets of cities and produce "upstanding" citizens, while doing nothing to end the conditions of poverty those children endured. This mentality affects how Americans think about and make laws regarding childhood, poverty, and what does or does not constitute abuse or neglect. In fact, the United States' obsession with the "safety" and "protection" of its children is thinly veiled and coded language used to justify its true and more insidious nature: to destroy the Black family (as well as Native American families, Brown families, and later immigrant families living in poverty).

Between 1929 and the 1960s, orphanages were replaced with foster care and programming to aid "poor children and families" (Forestdale, n.d.). However, it was not until the 1960s that this mentality of "programming for the poor" and foster care became the framework of the modern day family regulation system and the "foster care industrial complex." The modern family regulation system was developing parallel to the United States government's assault on Black, Native American, Brown, and immigrant communities; in some instances, this assault was on low-income white folks as well.

Key to the development of the modern family regulation system is the narrative of the "battered child syndrome." In 1962, the term "Battered Child Syndrome" was created to describe the clinical condition of severely abused, neglected, or maltreated children which could result in death (Kempe et al., 1985). Three years after the publication naming "Battered Child Syndrome," all fifty states had passed legislation requiring doctors to report suspected child abuse or neglect (Melton, 2004). Originating from the concept of "Battered Child Syndrome," as defined by Kempe, mandated reporting initially focused on disseminating information to doctors about how to identify and properly report abuse

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[1] In her 2020 article, Roberts connected the child welfare system and the criminal justice system as two pawns playing in the larger carceral regime. She elaborates upon this notion: "The misnamed 'child welfare' system, like the misnamed 'criminal justice' system, is designed to regulate and punish black and other marginalized people. It could be more accurately referred to as the 'family regulation system.'" (Roberts, 2020).

[2] The term kidnapped is not used as hyperbole. We believe this to be fact. When individuals move children across state lines it is considered kidnapping. Why then does this definition not apply to the actions of the state as well? The state has a simultaneous monopoly on both violence and the conceptualization of violence (Anter, 2019). Children during the Orphan Train movement were taken out of their culture, families, and homes and shipped across the United States because one white man, Charles Loring Brace, thought it would be best for them. Oftentimes many children did not know or understand where they were being taken and in some cases were forced to end all contact with their birth families (Brown et al., 2020). To understand the impact the Orphan Train Movement had on children please visit: https://socialwelfare.library.vcu.edu/programs/child-welfarechild-labor/orphan-trains/

[3] White Saviorism is a term used to describe white people who "help" Black people and people of color in a self-serving manner. White saviorism is most commonly associated with individual acts that perpetuate colonialism and imperialism, particularly in the African continent: volunteer tourism and missionary work, for example. Instead of allowing communities to make decisions for themselves, white people come in to "help" as a form of aid, perpetuating a dangerous narrative that white people must be centered in order for BIPOC oppression to end.

to authorities. Kempe's research was narrowly focused on the most severe forms of abuse (e.g., broken bones), but he generalized his findings to create a universal standard for any child suspected of experiencing abuse. This generalization was not only quite a leap, but was also dangerous. The family regulation system has become a tool of surveillance, which has been weaponized against Black communities, communities of color, and communities living at or below the poverty line. Shortly thereafter, CAPTA was passed, which "provides Federal funding and guidance to States in support of prevention, assessment, investigation, prosecution, and treatment activities" (Child Welfare Information Gateway, 2019, p. 1).

Around the same time, a feeling of moral superiority was being promoted through the creation of the "war on drugs" by President Nixon in 1971. By 1980, President Reagan had widely expanded the criminalization of drug use, particularly crack-cocaine, and the prison industrial complex (DuVernay, 2016). Importantly, Nixon's "war on drugs" invented the racialized myth of the crack-addicted baby, a pervasive stereotype that looms over the family regulation system to this day (Wexler, 2019).

Mandated reporting laws were born out of a movement to "clean up" and rid city streets of "child gangs" (Brown et al., 2020) and a nationwide panic around severe abuse observed in a small percentage of children (Mandatory Reporting Study, 2020). Instead of addressing some of the contributing factors to child abuse like historical trauma, patriarchy, and white supremacy, mandated reporting laws were passed that individualized issues of poverty and domestic violence as a failure of an individual or a family, rather than a failure of society to address the mental and physical well-being of its citizens. This attitude of moral superiority, paternalism, and victim blaming is one that continues to frame the family regulation system and has historically been used as a tool of political and economic agendas in America, including the war on drugs.

In this paper we will review research and analyze the implications mandated reporting laws have had on Black families (as well as Native American, Brown and immigrant families, including but not limited to all families who live at or below the poverty line)[4]. We will recommend, based on our research and experiences serving in the legal and social service sector, to abolish the family regulation system by ending mandated reporting laws. We do not believe that ending the family regulation system and mandated reporting laws will put an end to all abuse, nor do we promote ignoring violence towards children. Though the family regulation system purports and falsely claims to be about protecting children, when observing the experiences and realities of folks ensnared in the family regulation system and looking at data, we have concluded that the family regulation system is the largest perpetrator of violence, abuse, and neglect to children and families. Our intention is to clarify and affirm the latter narrative in order to chip away at the legitimacy of institutions operating within the family regulation system and to take a critical look at mandated reporting as a tool of white supremacy.

For far too long, Black mothers and families have had to endure family separation while their voices were silenced by powerful and well-funded institutions. From our research on Black scholars and the voices of Black moms, we, as authors, have learned about the racial disproportionality of the current family regulation system. We must get rid of it and work towards creating a world where Black voices and families have self determination over their own futures. This includes understanding how the terms "abuse" and "neglect" have been weaponized against Black, Native American, Brown, immigrant, and low-income families. This means that we must slowly gut, defund, and transition away from our society's reliance on punitive institutions like the State Central Registry--the "centralized" database of all child abuse, maltreatment, and neglect cases-- and toward funding and handing over power to Black, Native American, Brown, and immigrant communities

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[4] Operationalized by Christina Bush, the theory of anti-Blackness postulates that systemic racism in America exists "through the denigration, disenfranchisement, and disavowal of people racialized as Black" (Bush, n.d.). That anti-Blackness permeates all aspects of society is evident when looking at systemically racist policies and practices, de-facto segregation, redlining, misogynoir, and police violence.

and families.[5] A first step towards this goal is to end mandated reporting.

THE PURPOSEFUL AMBIGUITY OF MANDATED REPORTING AND ITS IMPACTS

Mandated reporting is a relatively new concept for social workers, dating back less than 50 years to the inception of the Child Abuse Prevention and Treatment Act in 1974. In its short life, however, the principle of mandated reporting has done significantly more harm than good. As previously stated, mandated reporting came about as a result of Dr. Kempe's research on "Battered Child Syndrome (BCS)," and the fear that ensued regarding child maltreatment, abuse, and neglect. "BCS" should be diagnosed when there is a presence "...of fracture of any bone, subdural hematoma, failure to thrive, soft tissue swellings or skin bruising, in any child who dies suddenly, or where the degree and type of injury is at variance with the history given regarding the occurrence of the trauma" (Kempe et al., 1962). It is noteworthy that federal mandated reporting legislation rests on abuse that is only the most serious, though due to the ambiguity of mandated reporting laws and the legal consequences of not reporting, over-reporting as a precaution dilutes what is actually a case of serious abuse and what is not. This over-reporting disportionately affects Black, Indigenous, and Latinx families.[6]

Mandated reporters are often inconsistent about the reporting of suspected child abuse, neglect, and maltreatment, both because of the unclear guidelines set forth by national law and because of the incongruence between mandating reporting and professional ethics (Feng et al., 2012). The threshold for mandated reporters in New York State is "any reasonable suspicion." Many professionals disagree on what constitutes reasonable suspicion, at what point to report, and how to go about this conversation with clients. The New York State Office of Children and Family Services Summary Guide for Mandated Reporters (2019) defines reasonable suspicion as "a suspicion that the parent or other person legally responsible for a child is responsible for harming that child or placing that child in imminent danger of harm. Your suspicion can be as simple as distrusting an explanation for an injury" (2019, p.2).

Given the wide range of professions that fall under mandatory reporting laws– doctors, nurses, social workers, psychiatrists, teachers– it is understandable that there is no consensus on how to interpret "reasonable suspicion." What that means to a doctor in a hospital setting is very different form what it means to a teacher in a kindergarten classroom, or a therapist in a counseling session. Specifically for medical professionals, evidence reveals that providers are more likely to report families and individuals of color even when presenting with the same injuries and demographic factors as white families and individuals (Hlavinka, 2021). This indicates that racial biases within the medical field are not limited to the care and compassion received by patients of color, but also extends to the trust and support they receive from their physicians and medical staff (Hlavinka, 2021).

Furthermore, research also suggests that even within professions there is no agreement on the threshold of reasonable suspicion, noting that this can vary from person to person, department to department, and specialty to specialty (Levi & Crowell, 2011). This ambiguity is purposeful and creates an environment where racial bias thrives. This continues the destruction of Black, Native American, Brown, immigrant, and low income families.

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[5] We would like to recognize that there are cases of severe and dire child abuse and neglect that, heartbreakingly, often go unstopped by governement entities, as interference only occurs when it is too late. Thus, we align with the same ideology as the upEND movement in that "we want to support the formation of communities and a society where harm does not occur in the first place and where harm does occur, communities are able to respond in ways that do not create more harm" (upEND, FAQs).

[6] "In calendar year 2019, 41.4% of New York Statewide Central Register of Child Abuse and Maltreatment reports involved children in families who identified as Black/African American, even though these children only make up about 23% of the NYC child population, and 45.4% of reports involved children in families who identified as Latinx/Hispanic, even though these children comprise 36.4% of the NYC child population. On the other hand, while 26.5% of NYC children are White and 14.1% of NYC children are Asian/Pacific Islander, these families make up 8% and 5.3% respectively of reports to the SCR" (Oversight-Racial Disparities in the Child Welfare System, 2020, p. 5).

Mandated reporting and the possibility of a report being made diminishes the strength of the therapeutic alliance and the clinical benefits of work between clinicians and their clients (and trust between doctors and medical staff and their patients). Critics of mandated reporting have long argued that having clinicians as mandated reporters damages the work that clinicians can do by disrupting the therapeutic alliance. The potential of reporting may hinder the work that a clinician can do with a client, as the client may be monitoring and censoring what they say throughout sessions, causing a rupture in the therapeutic alliance and diminishing healing and growth as a result. Critics note that this is a major concern for clinicians who utilize a psychodynamic or psychotherapeutic approach (Kalichman, 1999). If a client discloses that harm is occurring, the clinician is in the position to successfully deliver an intervention and discuss the root causes of the abuse. To report, the clinician or professional must break confidentiality, which has harmful effects on the client-clinician relationship (Kalichman, 1999).

How do social work practitioners justify the harm done through the family regulation system's mandating a report report while striving to achieve their code of ethics? Can they? Due to the legal ramifications of not reporting, does the mandated reporting law actually coerce professionals into reporting to prevent legal recourse? Does this ultimately disproportionately favor reporting over not reporting at all?

THE ARGUMENT TO KEEP FAMILIES TOGETHER

Historically, the narrative of the family regulation system has been couched in language like "protecting children," thus erasing the voices of directly impacted individuals and promoting stories that fit the narrative of white saviorism. If the social problem is framed as poverty or individual failure, then the intervention is separating families to preserve the child's safety. However, research demonstrates that, in most cases, keeping a family together is best, and reporting can be harmful to families (Kalichman, 1999). Thompson and Flood (2002) argued that the best way to protect children is to emphasize preventive and support services that would help with family preservation and maintaining family ties, even when it is unsafe for children to live with their parents. Research also indicates there is a specific pattern of cases that are reported and re-reported. The characteristics of these cases include, but are not limited to, social support deficits, family stress, and partner abuse (DePanflis & Zuravin, 2002). Families who fit this profile but use the services provided have been shown to be 33% less likely to have another report placed for them (DePanflis & Zuravin, 2002). This indicates that identifying proper support services for families to participate in is effective in reducing re-reporting (DePanflis & Zuravin, 2002). Given the main case characteristics, future considerations for increased support services should include aligning families with others to increase social support, psychoeducation around stress and abuse, and family violence intervention programs through a trauma-informed and culturally humble approach.

In addition to the pattern of report and re-report, there is also evidence for a high correlation between re-reporting and specific "risk" factors. Connell et al. (2006) found that family poverty was the strongest predictor of re-reporting. Other predictors of re-reporting include community poverty level, family history of substance abuse, and domestic violence. This strongly suggests a correlation between socioeconomic status, income level, mental health, and victimization--all of which are dictated by race in the U.S.--and re-reporting. These "risk factors" further reveal mandated reporting's continued legacy of oppression, systemic racism, and intergenerational trauma within the Black community (Hernández et al., 2005).

MODERN DAY RACISM: EFFECTS OF MANDATED REPORTING

It is evident that white supremacy is the ideological backbone of the family regulation system. Through the operation of the family regulation system, including the foster care system, the United States demonstrates that it believes the state will do a better job of parenting a child than those living in poverty, specifically Black folks, Indigenous individuals, immigrants, and people with disabilities. This is the intent of the family regulation system and has been since its formation; it is by choice, not coincidence, as was seen in the Orphan Train's movement to "clean up" urban communities. This kind of thinking has a dire legacy in the United States and must end.

Mandated reporting contributes to the racial disproportionality within the family regulation system at both state and federal levels. The first manuscript reporting racial disproportionality in the family regulation system dates back to 1972 (Billingsley & Giovannoni, 1972), and its findings continue to hold true 45 years later. In 2000, it was reported that Black children represented 38% of the foster care system while being only 16% of the national population (National Council of Juvenile and Family Court Judges [NCJFCJ], 2017). Between the years of 2000 and 2011, Black children were twice as likely to be removed from their parents care as white children (Sangoi, 2020). Black children were overrepresented in foster care in 46 of the 50 states in 2015 (NCJFCJ, 2017). In 2015-2018, only 9 out of every 1,000 cases in the United States reported to child protective services were confirmed cases of maltreatment (KIDS Count, 2018). In 2017, in California and New York, Black children were represented three times more in foster care than they were in the state's population (NCJFCJ, 2017). Of cases that were confirmed as maltreatment, in 2018, 18% involved Black families and 23% involved Hispanic or Latino families (KIDS Count, 2018). Thus, for 2018, children of color accounted for approximately 65% of all children in foster care throughout the United States (KIDS Count, 2018). As of 2020, children that are Black represent 23% of kids in the family regulation system while only representing 14% of the national population (KIDS Count, 2020).

While some states have universal reporting laws, others only require professional mandated reporters (Krase & DeLong-Hamilton, 2015). More than half of the 3.3 million reports of child maltreatment in 2011 were carried out by these professionals (United States Department of Health and Human Services, Administration on Children, Youth, and Families, 2012).

Black families and caregivers are more likely to be reported for maltreatment than white families (Miller, 2008; Putnam-Hornstein et al., 2013). In New York State, Black families and caregivers are disproportionately reported for child maltreatment by school employees via mandated reporting (Krase, 2015). The ongoing surveillance and involvement with the family regulation system reinforces negative stereotypes of Black individuals and families, such as the lack of ability to take care of their children without government assistance (Dettlaff et al., 2020).

While the state claims to protect children, state intervention in family matters is insidious and has far-reaching consequences that further compound the trauma of living in a white supremacist society. Additionally, the narrative that family separation benefits both children and parents is an outright falsehood disproven by research that indicates the negative impacts it has on the wellbeing of children and families (Rethinking Foster Care, 2014). In addition to research that proves the long-lasting trauma families experience due to state intervention, there is also a robust amount of research that points to a clear pipeline between foster care and prison (Center, 2018).

As explained by Dorothy Roberts (2002), mandated reporting has reverberating effects at the local and personal levels. Communities consisting of Black families are plagued by mandated reporting, surveillance, and separation, thereby enduring harm to their individual and collective identities. Each of these makes it difficult for people and families of color to build stable bonds and overcome additional disadvantages. Roberts (2008) reported a lack of community involvement, as well as diminished social connection, lower quality friendships, and less supportive bonds due to fear of child welfare intervention by the state and fear of the possible calls and reports made by disgruntled neighbors as a result of other social conflicts.

As Black and other communities of color continuously suffer from racist systems and policies, their negative health outcomes and poor living conditions, caused by white supremacy and the cultural imperialism of

America, are then used against them in the form of mandated reporting and state-led interventions like child removal. This perpetuates the historically traumatic narrative of Black families as unworthy or incapable.

CURRENT PRACTICES OF HARM

Mandatory reporting laws do not account for a reporter's own personal experiences, biases, or beliefs. There is a well-documented racial issue within the family regulation system, as discussed in the previous section. Historically, white, Anglo-Saxon, upper middle-class individuals have dictated what is appropriate, what is inappropriate, and what is "right" when it comes to parenting and family values. This notion of the "white lens" is clearly evident in the family regulation system where we see families punished for not meeting upper middle-class, Anglo-Saxon standards.[7] It is clear that the immediate need of children and families dealing with the family regulation system is the abolition of the family regulation system. It should be replaced with the integration of community-based services that are preventative and promote child, family, and community wellbeing, as well as the acknowledgement of the race-based motivation behind the trauma inflicted on children, families, and communities of color under the guise of this system. We also believe that the family regulation system should be defunded and the money reinvested back into the community, with community members at the forefront of deciding what gets funded.

VIII. CENTERING FAMILY SUCCESS

The family regulation system is made up of two arms: the legal industry and the social service industry. The entire industry sits below the legal and prosecutorial infrastructure that is dependent upon family court and reporting for its economic survival (Rethinking Foster Care, 2014). Ultimately, do families need more services, where they will come into contact with even more mandated reporters? Or do researchers, activists, impacted parents, lawyers, and other advocates need to push towards abolishing the state intervention system all together, while fighting for social change that will put an end to racial trauma and disparities?

Between the years of 2015-2018, less than 1% of cases reported to child protective services were substantiated, or found to be confirmed cases of maltreatment (KIDS Count, 2018). The most common finding nationwide in family court is one of neglect, not abuse (National Child Abuse Statistics from NCA, 2020). The charge of neglect is usually an indictment of the parent's ability to meet a child's needs due to poverty. The charge of neglect is how the family regulation system continuously punishes folks living at or below the poverty line, blaming them as an "individual failure," rather than systemic failure. Over and over research shows families involved in the family regulation system are most likely living at or below the federal poverty line (Joyce, 2019).

Reports show that the family regulation industrial complex spends tens of billions of dollars each year, with estimates citing that between 2004 and 2014 spending of state, local, and federal dollars reached up to 32 billion dollars each year (Sangoi, 2020). For scale, the state, local, and federal average annual spending on the Women, Infants, and Children Supplemental Nutrition Program, providing support and programs for children under three living in poverty, is 6 billion dollars (Sangoi, 2020, p. 131). Yet, with roughly five times as much being spent on the family regulation system, the dollars do not reach families and children in need of services and support; the vast majority of this spending was on "out-of-home placement": not keeping families together (Sangoi, 2020, p. 131).

The most appropriate use of resources for the family regulation system would be to develop services that "meet the needs of such families," and "to reduce the risk of recurrent allegations among families faced with economic challenges" (Connell et al., 2002, p. 584). In practice, this would mean prioritizing the voices of directly impacted individuals and communities by creating sustainable programs that are built around the demands of families involved in the family regulation

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[7] A recent example of this is the disproportionate number of marijuana-related reports on BIPOC folks in low socio-economic neighborhoods, and the heraliding of marijuana use as a form of self-care for white and upper-class parents (Ketteringham, 2019).

system. Directly impacted individuals, families, and communities have argued for decades that decreasing surveillance and oppressive infrastructure operated through mandated reporting will lead to less childhood trauma, greater intra-community trust, disclosure amongst participants and care providers, and overall greater wellbeing (Roberts, 2002).

The state-mandated intervention systems have operated as a means through which to control, manipulate, and oppress communities of color and those living in poverty. It is time for change. Building community resources and services would innately involve directly impacted individuals, families, and communities, who are the experts in their own lives and needs, by asking, "what do you need?"

A CALL FOR CHANGE: ABOLISH MANDATED REPORTING LAWS

Not only have we imagined, based on the voices of Black folks who have worked as lawyers, scholars, and who have been impacted by the family regulation system, what a world without the family regulation system *could* look like, but we have also highlighted the harm that the current system does and the values that control the current decision making processes within the system. The "child welfare" system we currently have is not working to protect children and families, nor is it increasing child wellbeing. It is a system deeply rooted in oppression, surveillance, and punishment of BIPOC communities and brutally enforces a white, Anglo-Saxon style of parenting. How do we prevent children and families from experiencing trauma at the hands of the family regulation system? What is a successful first step in abolishing the family regulation system?

We narrowed our focus to abolishing mandated reporting laws, which was directly inspired by Joyce McMillan's call to end Mandated Reporting. Without mandated reporting laws, we believe that clients would disclose more openly and productively in clinical work, at the doctor, and with teachers. In doing so, folks can actually get the adequate mental and physical health care they need and deserve. For example, due to mandated reporting at public hospitals, many pregnant people will not go to prenatal appointments for fear of a report being filed against them, especially due to any positive toxicology report (Khan, 2019). Without mandated reporting, birthing folks would more likely attend all prenatal sessions, which could in turn decrease the mother and infant mortality rates of both Black and non-Black birthing folks. In sum, trust can be built up between client and provider in systems that are historically oppressive and punitive, and clients will be able to get more out of services, because services will actually deliver their intended impact and interventions. Children and families' wellbeing will flourish because only cases that have actual merit or need will be reported and the fear of state-imposed trauma this system instills will be removed.

A world without an added layer of surveillance from mandated reporting means a world where there will be: 1) increased child wellbeing in communities where the family regulation system's presence is high; 2) less undue trauma to youth and families; 3) greater inter-communities and intra-community trust; and 4) less violence overall. As social workers, we also recognize the potential for less burn out and more time to work intimately with clients and community members. In this world, we imagine there will be greater collaboration amongst organizations, community entities, neighbors, and schools. Without the fear of mandated reporting hindering access to care or trust in authority figures, greater fidelity to services can be provided, relationships between families and schools can improve, and medical well-visits can be regularly attended. In this world, we imagine self-determination for families and choices made with consent and knowledge rather than in fear. We imagine communities solving their own problems and service providers, like social workers, stepping in only if requested. Love and justice are at the core of our call to end mandated reporting laws.

The implications of this research suggest that change is needed at several levels, including the individual, family, community, state, and federal. We demand that advocates, social workers, and lawyers take the lead from those who have been most impacted: parents who have experienced the family regulation system and children whose lives have been turned upside down due to family separation. Our hope is that this paper can spark a conversation more broadly amongst providers, including those working within the family regulation system, social workers in schools and hospitals, medical staff, and people who are unaware of the serious harms the family regulation system commits everyday in the name of "child safety."

RESEARCH LIMITATIONS

The researchers are passionate about contributing to this growing body of knowledge, and we want our scholarship to be used to bolster the existing advocacy of impacted parents to amend or abolish the family regulation system. As folks who have not been directly harmed by this particular system, we only understand the mechanisms through scholarly work and working directly with those most impacted. Often, directly impacted individuals are not given the option to engage with or draw conclusions about the systemic issues behind the family regulation system, but are rather forced to do so. As white researchers and academics, we are a part of the systems of colonialism and white supremacy that continue to marginalize those most impacted by this issue. Academia is predominantly an institution and tool of white supremacy, often stealing from and profiting off of the ideas and struggles of BIPOC, immigrants, LGBT+ individuals, people with disabilities, and poor communities. It is our hope that this research can be used as a tool by those most impacted to advocate for themselves and their communities, and as a conversation starter for service providers and mandated reporters.

DEDICATION

This research is dedicated to all of the children and families currently or formerly involved with the family regulation system. This research would not have been possible without the tireless support of many of our friends, family, and colleagues. A special thanks to Dr. Ellen Lukens, who pushed this team to be what it is, to KLS, without whom none of this would be possible, and to all of the people who volunteered their time to share with us their experiences with the family regulation system: JW, MGO, KS, ALD, NM, and DK. To our partners and loved ones who put up with our late nights and grammatical questions, thank you. To our editors, Caitlin and Sarah, we would not be here today without you. And, to Joyce McMillian, whose work continues to be a source of inspiration.

For further education about the impact of mandated reporting on families or to get involved in the movement to end the family regulation system, we urge you to check out the following: Movement for Family Power, JMacForFamilies, upEND, and Ancient Song Doula Services.

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Unique Causes And Manifestations of Eating Disorders Within Transgender Populations

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Transgender populations are disproportionately impacted by eating disorders and disordered eating behaviors; however, transgender clients lack access to affirming and culturally responsive mental health care and are frequently undiagnosed. In addition, conventional treatment models for eating disorders do not attend to the unique causes and manifestations of eating disorders among transgender people, which include: minority stress and gender trauma; gender dysphoria and lack of access to safe, gender-affirming treatment; safety concerns and the need for passing; cissexism and resulting disempowerment; and pervasive, harmful beauty standards coupled with hyper-scrutiny of trans bodies. This project includes a summary and analysis of the existing literature and data regarding the causes of and current treatment recommendations for eating disorders within transgender populations. It also suggests a social-work-led shift within eating disorder treatment to center the sociopolitical forces which so often lead to such diagnoses.

Keywords: transgender, eating disorder, culturally responsive treatment, minority stress, gender trauma, access to care, cissexism, anti-oppressive approach

UNIQUE CAUSES AND MANIFESTATIONS OF EATING DISORDERS WITHIN TRANSGENDER POPULATIONS

Despite limited representation of transgender bodies in both popular media and a lack of attention in clinical training to transgender concerns, research over the past several decades has indicated a high prevalence of eating disorders (EDs) and disordered eating behaviors among transgender populations. Research on health outcomes among transgender people and research on eating disorders are each underfunded (Feldman et al., 2016; Murray et al., 2017); few studies have been published on the intersection of the two that are generalizable at a population level. Those which do exist have focused nearly exclusively on transgender youth. A 2015 study of 289,024 students from 233 U.S. universities revealed that 15.8% of trans respondents had been diagnosed with an eating disorder, compared to 1.85% of cisgender, heterosexual women, and 0.55% of cisgender, heterosexual men (Diemer et al., 2015). The study also collected data on reported disordered eating behaviors among participants within the past month: 13.5% of trans respondents reported using diet pills within the past month, compared with 4.29% of cisgender, heterosexual women. Futhermore, 15.1% of trans respondents reported self-induced vomiting or laxative use within the past month, compared to 3.71% of cisgender, heterosexual women (Diemer et al., 2015). In collecting symptom-specific data, Diemer et al. identified behaviors in individuals who may not have received a formal diagnosis at the time of data collection due to either their nature or duration. Other Specified Feeding and Eating Disorder (OSFED) is generally considered more common among transgender people than the more widely recognized diagnoses of anorexia nervosa and bulimia nervosa, due to the unique manifestations of disordered eating motivations and behaviors among trans populations. A 2015 study of gender identity, sexual orientation, and self-reported ED diagnoses among college students (N=289,024) found that trans respondents (n=479) were more likely to report disordered eating behaviors generally, and particularly those consistent with a diagnosis of OSFED (Diemer et al., 2005). Other researchers have importantly identified that mortality rates for Eating Disorders Not Otherwise Specified (the DSM-IV diagnosis later renamed OSFED in the DSM 5) are comparable to those for bulimia nervosa (Arcelus, 2011); thus OSFED is no less dangerous than the well-known diagnoses.

Though exact rates vary across research studies, the general trend of higher rates of EDs among trans respondents are consistent. A 2016 study of 218 children and adolescents with gender dysphoria revealed that 13.3% had “eating difficulties” (Holt et al., 2016), and a 2012 study of 97 youth with “gender identity disorder” (a DSM-IV diagnosis which later became “gender dysphoria” in the DSM 5) demonstrated a 7% rate of EDs among its sample (Spack et al., 2012). Dangerously little research has been published on the experiences of transgender people of color (POC) navigating eating disorders. Indeed, only 30.42% of respondents (including only 4.5% Black and 5.96% Latinx) to the 2015 study (Diemer et al., 2015) and 11.3% of respondents to the 2016 study (Holt et al., 2016) were POC. Of the former, only 4.5% of respondents were Black and 5.96% were Latinx; the remainder of the 30.42% were comprised of Asian American Pacific Islander (AAPI), multiracial, Native American, and “unknown” respondents (Diemer et al., 2015). Spack et al. (2012) did not include data around participant race and ethnicity, likely indicating a lack of attention to inclusive participant recruitment, and a fairly racially homogenous sample by extension. In spite of this, high rates of eating disorders among BIPOC populations suggest that rates among trans people of color may be even higher (NEDA, 2018).

These statistics are cause for alarm, not only because of their contrast to data on cisgender youth, but because of the considerable dangers associated with eating disorders. EDs have “the highest rates of related medical complications, hospitalizations, and mortality of all psychiatric disorders” (Duffy et al., 2016, p. 136). This paper seeks to explore the extent to which eating disorders among transgender populations are influenced by sociopolitical forces. Social workers, who are trained to use an anti-oppressive, “social model” of mental health, are uniquely positioned to advocate and provide affirming interventions for transgender clients. Clinicians must consider five major contributing factors to eating disorders among transgender populations: 1) minority stress and gender trauma, 2) gender dysphoria and lack of access to safe, gender-affirming treatment, 3) safety concerns and the need for passing, 4) cissexism and resulting disempowerment, and 5) pervasive, harmful beauty standards coupled with hyper-scrutiny of trans bodies.

MAJOR CONTRIBUTING FACTORS

DISCRIMINATION-BASED STRESS AND GENDER TRAUMA

Minority stress was first introduced in 2003 to describe the result of repeated exposure to microaggressions and other forms of stigma and discrimation among lesbian, gay, and bisexual (LGB) individuals. Epidemiologist Ilan H. Meyer found that high levels of stress were associated with negative mental health outcomes (Meyer, 2003). The concept has since been expanded to other marginalized populations, including Black and Indigenous People of Color (BIPOC), transgender communities, and disabled people, among others. Experts recognize that the experience of transgender embodiment within a cissexist society precipitates gender trauma and stress (Kosciewicz et al., 2020). Moreover, for transgender POC this trauma is compounded by the violence of racism (Harrington, et al., 2006). Researchers have identified a relationship between stress, trauma, and maladaptive coping strategies such as disordered eating (Witcomb et al., 2015, p. 292); high rates of such behaviors and disorders among a population so vulnerable to stress and trauma are, unfortunately, unsurprising.

Despite limited research, there is significant evidence to suggest that the risk of disordered eating among trans people of color is heightened due to the compounding nature of marginalized identities and oppression. Legal scholar Kimberlé Crenshaw introduced the concept of intersectionality in 1991, noting the unique experience of those living at the intersection of multiple marginalized identities, and, consequently, subjugated by multiple systems of oppression. As Crenshaw writes, "the intersectional experience is greater than the sum of racism and sexism" (Crenshaw, 1991, p. 58). Thus, navigating an eating disorder becomes more complex for a transgender person of color than for a white or cisgender person.

GENDER DYSPHORIA AND LACK OF ACCESS TO SAFE, GENDER-AFFIRMING TREATMENT

Some transgender people experience gender dysphoria: a state of distress caused by the misalignment between their own gender identity and that which is associated with their sex assigned at birth. While the DSM 5 and the World Professional Association of Transgender Health (WPATH) Standards of Care recommend gender-affirming medical intervention such as hormone therapy and surgeries as treatment for gender dysphoria, lack of access to affirming care as well as limited effects of interventions may lead trans individuals to physically "transition" through disordered eating behaviors. For many transgender people, disordered eating can be seen as a method of "either suppressing or accentuating gender by changing the shapes of their bodies" (Kosciewicz et al., 2020, p. 73). For those assigned female at birth, this may mean weight loss to reduce hips, breasts, or buttocks, while those assigned male at birth may gain weight to de-emphasize shoulder breadth, among other characteristics (Kosciewicz et al., 2020). Transmasculine individuals (those assigned female at birth who are transgender and who identify with masculinity to a greater extent than femininity) may restrict their diet to induce amenorrhea, or the cessation of menses (Testa et al., 2017). As Chang et al. (2018) acknowledges, these behaviors, while dangerous, "may feel more accessible or actionable" than physical transition by medical means (p. 116).

Barriers to accessing gender-affirming care may fuel the desire to participate in harmful disordered eating behaviors. Financial limitations may include lack of health insurance coverage, high out-of-pocket cost of care, and limited free time in which to seek care. Geographic restrictions may also create challenges to accessing a gender-affirming provider in close proximity. Finally, lack of support in familial/peer relationships and potential safety risks in altering one's presentation and medical barriers, such as pre-existing conditions that might interfere with physical transition or require a particular medical specialist, restrict many transgender people from accessing affirming care. Physical transformations by way of disordered eating behaviors may be heightened among transgender POC who experience significantly more limited access to gender-affirming medical care, beyond that of their white counterparts (Howard et al., 2019). An analysis of the impacts of such barriers is explored in greater depth in the "Critique of Current Treatment Model" portion of this project.

SAFETY CONCERNS AND THE NEED FOR *PASSING*

The concept of *passing* was initially devised in reference to light-skinned Black Americans who navigated anti-Black racism in the country by presenting themselves as white; historians trace this strategy back to the early years of slavery in the United States (Hobbs, 2014). *Passing* has since been adopted by transgender communities to refer to the phenomenon by which transgender people are seen by others as cisgender people of their affirmed gender identity. *Passing* has been rejected by many transgender activists, as to some, the term suggests something inherently "correct" or "successful" about appearing cisgender. Additionally, passing is not achievable for many people, depending on limitations of hormonal and surgical transition as well as gender identity (one might consider what it means to "pass" as non-binary). It should be noted that *passing* is not a goal for all transgender people, just as it has certainly not been a goal for all Black people. Many individuals, whether marginalized by transgender identity, race, or both, equate passing to a loss of personal identity and of community/familial ties (Hobbs, 2014).

Although gender dysphoria is understood by behavioral health providers primarily as a mental health concern, passing as one's gender identity has significant societal implications related not only to acceptance, but also to safety. Those "visible" as transgender are particularly susceptible to transphobic discrimination, including social othering, microaggressions, and verbal and physical harrassment and violence. Transgender individuals are socialized to remain hyper-

aware of their appearance to onlookers as a matter of survival, and many recognize that "biological sex characteristics related to weight and shape . . . may reduce how often they are perceived and treated as the gender they experience themselves to be" (Testa et al., 2017, p. 928). However, passing may precipitate greater safety risks for trans individuals. As activists and theorists alike note, passing as cisgender may be perceived as "deception" by cisgender people (Billard, 2019, p. 463). All too often, "deceived" cisgender people respond to the disclosure of another's transgender status with rage and sometimes fatal violence. Passing as cisgender may be of even greater concern to Black and Brown transgender women, who face an epidemic of violence. In 2020 alone, at least 44 transgender and gender nonconforming people, almost exclusively Black and/or Latinx and transfeminine, were victims of fatal transphobic violence nationally (HRC, 2020). Since 2015, the Human Rights Campaign has recorded a total of 158 deaths (HRC, 2020; HRC, 2019; HRC, 2018; HRC & TPOCC, 2017; HRC & TPOCC, 2016; HRC & TPOCC, 2015). This devastating pattern underscores the complexity of the drive to "pass" (or not) for transfeminine people of color in particular.

The role of passing in driving disordered eating behaviors is complex. One 2018 study of transgender adults (n=452) found a slightly elevated rate of disordered eating among non-binary respondents who had been assigned female at birth, compared to trans men, trans women, and non-binary people assigned male at birth (Diemer et al., 2018). While researchers could not identify a clear cause for the difference, they noted the impact of visible gender-nonconformity (in other words, "lack of passing") often expressed by non-binary trans people and the possibility that some may turn to disordered eating behaviors as a response to the resulting minority stress in a highly binary and conformist society (Diemer et al., 2018). In this sense, EDs may be employed by trans people either as a strategy to control the body's shape and "pass" as a cisgender man or woman, or result from a manifestation of stress and anxiety experienced by those who navigate the world as "un-passable" by virtue of their non-binary gender expression. For some, both factors may be at play.

CISSEXISM AND RELATED DISEMPOWERMENT

In response to both pervasive cissexism and gender dysphoria, trans people may turn to disordered eating behaviors as a means of reclaiming a sense of power. As Chang et al. (2018) acknowledge, such behaviors may serve to "provide a sense of control or influence over one's body size or shape" (p. 116). The distress caused by a misalignment between internal identity and the gendered meanings attached to bodies in Western cultures should not be underestimated; indeed, disordered eating may "facilitat[e] a level of omnipotent control in the midst of overwhelming and unbearable somatic feelings, and distress because of one's inability to resolve the conflict between the reality of their gender experience and their heavily defended-against attachment that the body spells as gender's reality" (Kosciewicz et al., 2020, p. 68). Thus, the sense of control some may achieve through disordered eating behaviors may extend beyond those behaviors' visible impact on the shape or size of the body.

HYPER-SCRUTINY OF TRANS BODIES AND PERVASIVE BEAUTY STANDARDS

Transgender and cisgender people alike risk profound influence by narrow societal beauty standards, though this may be compounded for transgender people who are socialized into a gender role different from their affirmed gender and who may internalize multiple, even contradictory body expectations. As Witcomb et al. (2015) argue, "Trans males may internalize the same ideals that natal females do with regard to the ideal aspects of being female, despite desiring to be male" (p. 291). The drive for thinness may be compounded by trans identity, given a perceived correlation between weight loss and the "suppress[ion of] features of the birth assigned gender and [accentuation of] the features of the identified gender" (Witcomb et al., 2015, p. 292). Hypervisibility and hyper-scrutiny of trans bodies perpetuates ideals that are even more extreme than those imposed upon cisgender people, "because they are expected to 'prove' themselves as being 'man enough,' 'woman enough,' or 'trans enough'" (Chang et al., 2018, p. 116). These dangerous beauty expectations are based in whiteness, and the fatphobic standards that underlie them, with roots in anti-Black racism. Sociologist Sabrina Strings unravels the history of fatphobia in her text Fearing the Fat Body. Though the current dominant culture in the United States and Europe justifies societal discrimination against fat bodies by deeming them necessarily "unhealthy," this was not the case historically. Indeed, fatness historically came to be associated with "savagery" and "racial inferiority" amidst European colonization of Africa (Strings, 2019, p. 4). The impact this history has had on Black Americans more recently is nuanced. A 2014 series of focus groups comprised of Black women students (n=31) at a large university explored various body image concerns and values among participants. While all participants reported being in some way affected by beauty standards based in whiteness, many also reported that they saw "curviness" as "optimal" for Black women, and considered thinness to be "for white people" (Awad et al., 2016, p. 550). Regardless of its manifestation, there is widespread awareness of body image standards. These standards understandably impact transgender people's relationships with and expectations around their body, shape, and size. Pressures around conforming to beauty standards are compounded significantly for trans POC (Johnson, 2019).

CRITIQUE OF CURRENT TREATMENT MODEL

The development of gender-affirming, culturally responsive interventions for eating disorders among transgender populations is of paramount importance; however, clients seeking healing face numerous obstacles stemming from a dearth of competent providers, comprehensive research, and safe(r) community spaces.

ACCESSING INCLUSIVE TRANSGENDER COMMUNITY

For many trans people, and especially trans youth, community may seem altogether nonexistent. As Davis et al. (2018) point out, "the absence of trans-peers and a trans-social network can reinforce the maladaptive behavior that many trans-youth utilize to erase or reconstruct their identities" (p. 56). Even when community is available, the persistent stigma around eating disorders often silences communities from healing through necessary conversation. This lack of openness may be explained by the reality that even in their own communities, vocal trans people risk not only "emotional vulnerability," but also "reveal[ing] the fragility of their gender presentation" (Kosciewicz et al., 2020, p. 85). As in many marginalized communities, the value of "pride" in oneself and one's body in the face of systemic violence may backfire when other members feel unable to acknowledge and unpack their internalized oppression.

LIMITING NARRATIVES & UNDERDIAGNOSIS

Transgender people are unrepresented in the singular, dominant "eating disorder narrative," which narrowly defines those with eating disorders as thin, white, straight, cisgender women. Consequently, disordered eating behaviors in trans people may go unrecognized--or even vehemently denied--altogether. Kosciewicz et al. (2020) quote one interviewee who explains: "I've been told for so many years that I don't have an eating disorder, there's nothing wrong with me, I'm being dramatic" (p. 83). Research indicates that clients of color, particularly Black clients, are significantly less likely to be diagnosed with an eating disorder when displaying the same eating and exercise behaviors and thought patterns as their white counterparts and non-Black counterparts of color (NEDA, 2018). Underdiagnosis may also be attributed to an over-attribution of symptoms to gender dysphoria because "the conversation about bodies may be so focused on gender that important information is missed" (Chang et al., 2018, p. 115). Certainly the relationship between gender dysphoria and weight dysphoria or body dysmorphia is a nuanced one.

RECONCILING CONTRAINDICATED INTERVENTIONS

This complex comorbidity of gender dysphoria and body dysmorphia must be explored further. On the surface, the most common treatment approaches to each are in fact contraindicated. Chang et al. (2018) articulates the dangerous potential contradiction clearly:

> A common message in society as well as in eating disorder treatment and recovery communities is 'Just accept yourself as you are.' Although this may be an ideal or goal to strive toward regarding body size and weight acceptance, this message can be misapplied in a distorted and harmful way to trans people. It can suggest that trans people should just learn to accept and live in accordance with the gender identity associated with their sex assigned at birth. (p. 117)

This failure to affirm and validate gender identity in eating disorder treatment drives potential patients away from seeking care in the first place. Duffy et al. (2016) report on a study of transgender people with a history of eating disorder treatment, sharing that of the 84 participants, "some even expressed wishing they had never gone to treatment at all, despite acknowledging that it was likely life saving" (p. 144). Gender-competent care and empathy are critical if providers hope to "heal" their patients from what patients may experience as bringing about affirming physical change and a sense of control. Kosciewicz et al. (2020) emphasize that there is "psychic and physical pain involved in relinquishing the ED as the primary means for self-regulation" (p. 69).

MEDICAL TRANSITION & GATEKEEPING

Further, acknowledgement and diagnosis of an eating disorder for a trans patient may prevent access to gender-affirming medical treatments that could alleviate the need for "self-transitioning" behavior. Because trans individuals require clearance from a behavioral health provider to access surgeries, the existence of any mental health diagnoses may halt the process--and, while WPATH Standards of Care do currently clarify that "mental health conditions may be present" (if "reasonably well managed"), "health-care providers may believe that a client should resolve eating-disordered behavior before they are appropriate for undergoing GCMIs" (Testa et al., 2017, p. 928). Such pitfalls would likely be ameliorated by adequate training of medical professionals. At the moment, few training programs offer information that is specific to transgender populations (Duffy et al., 2016). Given this lack of education, experiences of eating disorders specific to transgender populations are easily ignored. Popular treatment models for eating disorders often target behavioral changes with insufficient attention to their underlying causes, and can thus be harmful for the transgender populations they may seek to serve. In part, limited research on the subject of transgender patients and eating disorders is to blame. Without an understanding of how access to physical transition can impact mental health outcomes and level of body satisfaction for transgender people, clinicians risk conflating client body dissatisfaction rooted in gender dysphoria with a negative self-image that centers around size and/or weight. Nutritionists, dieticians, and doctors are limited in their ability to apply nutritional needs to transgender clients, due to a lack of guidelines on the calculation of such needs or ideal body weights for clients who are on hormones (Kosciewicz et al., 2020).

INACCESSIBILITY OF CARE

Despite recent advancements in the clinical treatment of eating disorders among transgender populations, effective, gender-affirming interventions remain largely inaccessible to the most marginalized trans individuals. Transgender people, and particularly transgender POC, are disproportionately impacted by poverty and homelessness, and thus face significant financial barriers in access to care (National LGBT Health Education Center, 2018). Despite recent policy advocacy, many insurance plans still exclude gender-affirming medical treatments from coverage (National LGBT Health Education Center, 2018). Even for those with access, limitations remain as to what changes existing treatments can facilitate. Although testosterone therapy facilitates body fat redistribution, it brings with it a wide variety of other physical changes with which an individual may not identify (such as facial/body hair or a deeper voice). Though Witcomb et al. (2015) identify that "the body parts that were most reported to cause the most dissatisfaction were those associated with body shape" (p. 291), these may be the very adjustments most difficult to attain through current medical interventions, as they may be "relating to skeletal changes at puberty" that are irreversible (Witcomb et al., 2015, p. 288). Further limitations of medical intervention are demonstrated by the psychological and emotional effects of pubertal suppression on transgender pre-teens, as such intervention can leave them "looking younger than their peers," causing distress (National LGBT Health Education Center, 2018, p.3). While such medical advancements may fall beyond the purview of a social worker, clinicians must be informed on what their transgender clients may experience as deterrents to accessing medical interventions.

PROMISING PRACTICES

For those working with a younger population in a clinical setting, early intervention is critical. The National LGBT Health Education Center recommends that treatment for eating disorders begin prior to adolescence when possible, in order to prevent long term health consequences (National LGBT Health Education Center, 2018). For those working with transgender clients of any age who experience disordered eating, existing literature suggests a few promising practices: unsettling "diagnosis"; querying "acceptance"; holding space for mourning; and utilizing modalities and frameworks which acknowledge the impact of discrimination-based stress, trauma, and attachment disruption on clients. Given the potential contraindication of healing approaches to eating disorders and gender dysphoria, Chang et al. (2018) recommend that practitioners not designate some patients' concerns as either diagnosis, "but rather as both or an interaction of the two," employing "the dialectic of acceptance and change that is integral to mindfulness-based approaches such as ACT and DBT" (p. 117). Koscieweicz et al. (2020) open a critique of the very notion of mental health diagnosis. As they point out:

> We can challenge the normative treatment model of asking clients to learn to love their bodies by dismissing body dissatisfaction as a purely cognitive distortion. For all of our clients (especially trans and GNC people of color) the body exists within a social, political, and historical context that has been a place of both power and violence. (p. 79)

By rejecting the "medical model" of mental health in favor of a "social model," practitioners can identify the sociopolitical forces culpable for both gender dysphoria and disordered eating. Acknowledgement of this reality requires that clinicians guide clients through the simultaneous processes of mourning and behavioral shift. As Kosciewicz et al. (2020) write, "this tolerance for the uncertainty, the unknowability of the outcome of mourning, is crucial to the treatment of clients who are reliant on disordered eating behaviors to defend against the body/psyche disjuncture" (p. 69). Utilization of the minority stress framework is one component of anti-oppressive practice, which emphasizes the very real implications of socially constructed (but historically enacted) gender identity and cissexism.

LIMITATIONS

Existing research on eating disorders among transgender populations is significantly lacking, and that which does exist centers almost entirely on the experiences and diagnoses of white transgender youth. In order to begin to understand the impact of interlocking systems of oppression on transgender people of color, disabled transgender people, and those with other compounding marginalized identities, researchers must dedicate energy to the intentional recruitment of diverse respondents. Additionally, current research largely omits experiences of transgender adults, greatly limiting opportunities for eating disorder professionals to develop best practices when working with those beyond adolescence. Though many sociopolitical factors driving EDs are consistent across age groups, transgender adults may be rendered further vulnerable to disordered eating behaviors if these are driven by gender dysphoria and medical transition has already been "completed." Indeed, much is left to learn regarding the treatment of gender dysphoria for those who have seemingly reached the "limits" of what physical transition (hormonal and surgical) can provide.

CONCLUSION

This review of existing literature reveals that people who are transgender are disproportionately impacted by disordered eating due to forces that extend far beyond the "purely psychological" (Koscieweicz et al., 2020). Social workers, who embrace an anti-oppressive, "social model" of mental health, are uniquely positioned to advocate for and provide affirming, evidence-based interventions (Koscieweicz et al., 2020). Such interventions reject negative body image related to gender dysphoria as "purely cognitive distortions" and ground treatment in the validation of transgender clients' lived experience with forces of oppression (Koscieweicz et al., 2020). In this sense, social workers have the opportunity not only to address the unique needs of individual clients, but also to carry forward the work of activists past and present committed to dismantling cissexism, racism, sexism, and other forces of oppression in society at large.

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Violence Against Indigenous Women in the United States: A Policy Analysis

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Disproportionate levels of violence, disappearance, and murder are endemic among Indigenous women in the United States (U.S.). The prevalence of such violence has persisted for centuries, with little direct action taken to elevate the issue, protect Indigenous women, and hold individual and systemic perpetrators accountable. As a result, Indigenous women in the U.S. face various forms of violence at 2.5 times the rate of non-Indigenous women, with murder being the third leading cause of death. A staggering 94% of Indigenous women experience sexual violence in their lifetime (Urban Health Institute, 2019).

Through an analysis of existing and new legislation aimed at addressing the issue of violence against Indigenous women, we reveal the ways in which policies have fallen critically short of achieving this mission, highlight the strengths of recently enacted legislation, and provide recommendations for implementation in order to truly prevent violence, and therefore to protect and empower Indigenous women.

VIOLENCE AGAINST INDIGENOUS WOMEN IN THE UNITED STATES: A POLICY ANALYSIS

Indigenous women are experiencing endemic-levels of violence, disappearance, and murder, yet there is little to no accountability for the violence being inflicted upon them (Salam, 2019). Furthermore, a lack of awareness of these human rights abuses, among the public and policymakers alike, has led to far too few efforts toward protection from and prevention of such violence. It is time for Indigenous women to be guaranteed their rights to protections under the United States (U.S.) government, ensuring justice and safety in all jurisdictions. This paper will examine the lack of protection for Indigenous women and girls under U.S. government policy, and the characteristics, context, and responses to violence and abuses against them.

No person should ever experience psychological or physical harm. Any act of violence is a violation against humanity. The United Nations recognizes violence against women to be "any act of gender-based violence that is likely to result in physical, sexual, or mental harm or suffering to women, including threats, coercion or deprivation of liberty, whether occurring in public or in private life" (United Nations Inter-Agency Support Group on Indigenous Peoples' Issues, 2014, p. 1).

In a brief review of the literature on violence against Indigenous women, this paper will first present the prevalence and severity of this social problem, and then evaluate new and existing protections for Indigenous women under current U.S. law. Building on these protections, this paper will make recommendations for further changes and approaches to implementation necessary to advance the rights, health, and safety of Indigenous women. For the purposes of this paper, we use the term "Indigenous" to refer to Native American, American Indian, and Alaska Native women.

VIOLENCE AGAINST INDIGENOUS WOMEN: A SEVERE YET IGNORED SOCIAL PROBLEM

Indigenous women's and girls' experiences of violence are a reflection of the U.S. history of colonization, extreme poverty, and the exclusion of their wider communities—best contextualized in terms of the intersections of race, disability, age, sex, and location, in addition to mutually reinforcing forms of inequities. These conditions ensure that they do not benefit to the same extent as their non-Indigenous counterparts from services which would otherwise protect them from violence and support their ability to seek redress when it does occur (Inter-Agency Support Group on Indigenous Peoples' Issues, 2014). Rates of violence towards Indigenous women are 2.5 times higher than the rate of violence towards non-Indigenous women in the U.S., with estimates ranging from 46-91% of Indigenous women compared with 7-51% of non-Indigenous women (Burnette & Cannon, 2014). The Indian Law Resource Center (2020), a leading non-profit legal and advocacy resource organization for Indigenous people, found that four out of five American Indian and Alaska Native women experience violence, and more than one in two experience sexual violence (p. 1). These experiences of violence lead to significant trauma, substance use, depression, and other mental and physical health issues (Loerzel, 2020). Additionally, children of Indigenous women who experience intimate violence also experience high stress and anxiety, low self-esteem, and aggressive behaviors (Burnette & Cannon, 2014).

A key contributor to such violence is the fact that cases have not received attention or interventions whatsoever from any authoritative agency in centuries. While Indigenous women were once held in high esteem, given great respect and reverence among their tribes, the cultural erosion of Indigenous societies as a whole has been cited as a precursor to the violence Indigenous women face in their communities today (Burnette & Hefflinger, 2017). The U.S. colonial government system has failed to appreciate, preserve, and affirm the humanity, cultures, lands, territories, and resources of Indigenous peoples. Historical trauma refers to the cumulative emotional and psychological wounding over lifespans and across generations, emanating from massive group trauma experience (Brave Heart, 2003). Since multigenerational trauma continues as a consequence of such historical oppression, this trauma is seen as both a cause and a consequence of the normalization of violence towards Indigenous women in society (Burnette & Hefflinger, 2017).

Indigenous peoples all over the globe experience cultural and individual oppression. Identifying the best way to restore Indigenous women's rights to safety, health, and autonomy is not only crucial to empowering Indigenous women, but to empowering Indigenous culture as well. Indigenous women and girls play essential roles in maintaining community resilience and wellbeing, acting as vital keepers of cultural identity and tradition. When their rights are violated through violence and coercion, such human rights violations "[constitute] a violation of the sanctity of the ecological, spiritual and cultural identity of indigenous peoples as a whole" (Inter-Agency Support Group on Indigenous Peoples' Issues, 2014, p. 2). For Indigenous culture to flourish, programs must go beyond merely solving crimes against Indigenous women to preventing these crimes altogether. By focusing on how to empower and protect Indigenous women in the U.S., we can learn more about how to protect Indigenous peoples, cultures, and traditions worldwide.

CURRENT POLICY INTENDED TO EMPOWER INDIGENOUS WOMEN: THE VIOLENCE AGAINST WOMEN ACT (VAWA)

A key policy aimed at empowering Indigenous women is the Violence Against Women Act (VAWA). VAWA was introduced in 1994 as the first federal bill of its kind, acknowledging and addressing domestic violence and sexual assault as crimes. This paved the way for increased protections and support for women at federal, state, and local levels (NNEDV, 2020). The bill requires reauthorization every five years, and each renewal brings about key expansions in support for enhanced or newly-specified priorities, such as housing programs for victims of domestic violence or the implementation of culturally-competent services (NNEDV, 2020). The bill is key in raising awareness of violence against women and increasing support for victims and those impacted by sexual assault, stalking, rape, trafficking, and domestic violence.

The Violence Against Women Reauthorization Act of 2005 was the first to introduce plans to address violence experienced by Indigenous women and girls, specifically acknowledging the disproportionate level at which Indigenous women experience gender-based violence (Burnette & Cannon, 2014). As a result, section 903 was added to the bill, mandating the Attorney General (AG) to consult with Indian tribal governments on a yearly basis. These consultations afford an opportunity to provide recommendations to the AG regarding the federal administration of tribal funding for programs offered under VAWA, enhancing protection of Indigenous women from various forms of violence by improving the federal response—or lack thereof—to such violence (Salam, 2019; National Indigenous Resource Center, 2020).

The next iteration of the bill—the Violence Against Women Reauthorization Act of 2013—strengthened protections for Native American women and girls as a result of collaboration among the Indian Law Resource Center, the National Congress for American Indians Task Force on Violence Against Women, Clan Star, Inc., and the National Indigenous Women's Resource Center (Indian Law Resource Center, n.d.). Specifically, provisions were added to restore tribal criminal authorities to target and address violence inflicted upon Indigenous women and girls by non-Indian perpetrators on tribal land. This provision, known as the Special Domestic Violence Court Jurisdiction (SDVCJ), was instrumental in ensuring that Indian Nations can effectively investigate, punish, and hold perpetrators of violence—Indian and non-Indian alike—accountable for the harm they cause towards Indigenous women on tribal lands (Indian Law Resource Center, n.d.).

While the important addition of SDVCJ could benefit tribes in the 48 contiguous U.S. states, because of restrictive land resettlement laws, the federal government does not recognize tribal land as "Indian country" in Alaska (Indian Law Resource Center, n.d.). Under 18 U.S.C. § 1151 and 40 C.F.R. § 171.3, Indian country is defined as:

a. all land within the limits of any Indian reservation under the jurisdiction of the United States Government, notwithstanding the issuance of any patent, and, including rights-of-way running through the reservation;

b. all dependent Indian communities within the borders of the United States whether within the original or subsequently acquired territory thereof, and whether within or without the limits of a state; and

c. all Indian allotments, the Indian titles to which have not been extinguished, including rights-of-way running through the same. (U.S. Environmental Protection Agency, n.d.)

Because Alaskan tribal land does not fit this definition, section 910 of VAWA 2013 cites Special Rule for the State of Alaska (S.47-Violence Against Women Reauthorization Act of 2013). As a result, the SDVCJ currently applies to only one of 229 Alaskan tribes, thus excluding 40% of federally recognized tribes from these reforms (Indian Law Resource Center, n.d.). Jurisdictional complexities, in addition to insufficient resources for investigating and prosecuting those who commit crimes, add to the already high levels of vulnerability of Alaska Native women and girls,who make up 19% of the state population, but 47% of reported rape victims (Alaska Native Women's Resource Center, 2019). The Violence Against Women Reauthorization Act of 2019 (HR 1585), which is currently awaiting consideration in the Senate (Congress.gov, 2019), addresses this issue by introducing a pilot program that would allow five Alaska Native tribes to exercise SDVCJ (Alaska Native Women's Resource Center, 2019). VAWA 2019 will also add sexual violence, sex trafficking, stalking, and assault of law enforcement or corrections officers to the list of crimes Indian Nations can prosecute (Indian Law Resource Center, 2019).

CURRENT POLICY'S LACK OF EFFECTIVENESS IN PROTECTING INDIGENOUS WOMEN'S RIGHTS

The VAWA limits tribal prosecution of non-Indian perpetrators to those with prior connections to the tribe, but should expand to include those who commit any act of violence that is likely to result in physical, sexual, or mental harm or suffering to women or girls. Although evidence is limited, available studies indicate that this legislation is not achieving its intended goal of addressing and prosecuting crimes with the specific intent of increasing protections for women and girls (NNEDV, 2020). For example, while VAWA 2013 introduced legislation allowing tribes to charge non-Indian perpetrators of violence against women for their crimes, Crepelle (2020) highlights that tribes only have the authority to prosecute such perpetrators for three specific crimes: domestic violence, dating violence, and protective order violations (p. 60). Due to this limitation, tribes lack authority in prosecuting additional crimes committed during these same circumstances, such as child abuse, stalking, and other violent crimes, which often include children, women, and men, with sometimes dramatic consequences for entire tribes (Crepelle, 2020). These circumstances are exacerbated by a preexisting lack of protections for Indigenous women, including high rates of poverty and limited resources for law enforcement to put towards prevention efforts (Creppelle, 2020, p. 63).

VAWA also neglects to uphold and advance tribal sovereignty, a necessary facet of Indigenous women's well-being. VAWA lacks substantial compatibility with United States legal processes and procedures (Allison, 2019). This not only constitutes a significant burden on tribes to exercise civil jurisdiction but also helps to bring into focus the scope of oppression imposed by the United States government. VAWA does not provide any sense of consideration for historical oppression and genocide against Indigenous women, nor is it inclusive of Indigenous perspectives or demonstrate cultural reverence. As it does not include support for the safeguarding of sovereignty, VAWA seeks to strengthen a legacy of white supremacy and heteropatriarchy. As a result, VAWA does not adequately address the significance of violence towards Indigenous women, and fails to address the systemic causes and mediators of gender-based violence and genocide (Maxwell & Robinson, 2019).

While VAWA has come a long way since its introduction in 1994, it is clear that more work is needed based on the disproportionate levels of violence faced by Indigenous women throughout history and still today (Burnette & Cannon, 2014; Creppelle, 2020). As the SDVCJ does not apply to all tribes, most Indigenous women are not afforded the protections that the VAWA 2013 amendment celebrates (Allison, 2019). Despite increasing the list of crimes Indian nations can charge against (Indian Law Resource Center), VAWA 2019 does not provide a means of preventing the overwhelming levels of violence, abuse, and genocide imposed upon Indigenous women. In order to ensure safety and empowerment of Indigenous women, the scope of protections should include violence prevention efforts as well as accountability measures that apply to all tribal jurisdictions.

URGENT SOLUTIONS: SAVANNAH'S ACT, NOT INVISIBLE ACT, AND CHANGES TO VAWA 2013

Historically, criminal justice systems on reservations and in Indian country have created more barriers to investigating crime than to attaining solutions. Prevention, investigation, and prosecution of crimes against Indigenous women are often inconsistent or incomplete due to several different agencies—including the FBI, tribal police, and U.S. attorneys—working with conflicting protocol (Pao, 2020). In this section, we first review two recent acts that aim to combine and coordinate efforts to better protect Indigenous women and then propose a change to VAWA 2013 that would strengthen the ability to hold perpetrators of violence accountable.

TWO RECENT ACTS AIMING TO BETTER PROTECT INDIGENOUS WOMEN

In response to the inconsistency that has allowed abuse, disappearance, and murder of Indigenous women to continue, two acts were recently signed into law to enhance cohesion and diligence in protecting Indigenous women. Specifically, the first law, Savannah's Act (Public Law No: 116-165), signed into law in October 2020, requires the Department of Justice to create a task force made up of members from various agency bodies to ensure all teams are collaborating and can devise a concrete plan to investigate a crime. In creating a task force, the Department of Justice will also be required to conduct trainings for each agency, from the Bureau of Indian Affairs police all the way to the FBI, in order to establish each agency's role in locating missing women on and off tribal lands or investigating crimes against Indigenous women (Pao, 2020). Savannah's Act also requires transparency from the Department of Justice through recording data and reporting statistics on missing and murdered Indigenous women (Congress.gov, 2020).

The second law recently enacted is the Not Invisible Act (Public Law No: 116-166), which was also signed into law in October 2020. Also working to increase coordination efforts, this Act focuses on establishing more robust efforts to prevent murder, trafficking, and violence towards Indigenous women. Mandated by law, the Department of the Interior will designate an official from the Bureau of Indian Affairs to spearhead prevention by establishing grants, programs, and recommendations to combat violence towards Indigenous peoples (Sanchez, 2020). Furthermore, the Act creates an advisory committee on violent crime comprised of survivors, service providers, and members of law enforcement.

A NEW DIRECTION: PROPOSED CHANGES TO VAWA 2013

In order for these two laws to be effective, criminal authority must be restored to Indian Nations. According to a study by the National Institute of Justice, 97% of Indigenous women have been victims of violence at the hands of at least one non-Indian perpetrator during their lifetime (Rosay, 2016). If we truly aim to protect and provide justice for Indigenous women, girls, and their families, the Special Domestic Violence Court Jurisdiction (SDVCJ) provision introduced in VAWA 2013 must be implemented in all Indian Nations. As mentioned earlier, while VAWA 2019 proposes a pilot program to introduce and exercise the SDVCJ in five Alaska Native tribes (Alaska Native Women's Resource Center, 2019), it is critical that the SDVCJ be implemented in all tribes and reservations as soon as possible. Until then, non-Indian perpetrators will not be held accountable, and Indigenous women and girls will still be vulnerable to endemic-level violence, murder, and disappearance.

IMPLEMENTATION OF APPROACHES: RECOMMENDATIONS FOR PROTECTING INDIGENOUS WOMEN'S RIGHTS

As evident in this review of literature, it is important not only to pass laws, but also to implement them effectively and equitably so that the rights, health, and safety of Indigenous women can be protected and advanced. The two new laws—Savannah's Act and the Not Invisible Act—complement each other to streamline prevention efforts among federal, state, and Tribal officials to strengthen justice and public safety in tribal communities. As both laws were passed with wide bipartisan support and sponsorship, it is promising to see that this crisis is being recognized and prioritized across party lines. Through grant funding from the U.S. Depratment of Justice's Office on Violence Against Women, Savannah's Act incentivizes tribal communities by providing increased funding to jurisdictions that implement guidelines created by the Act (The Navajo Nation, Office of the President and Vice President, 2020; Department of Justice Office on Violence Against Women). Grant funds can be used towards training for law enforcement officers and data collection and reporting to the Attorney General (S.227-Savanna's Act, 2020). Increased funding to ensure the Act is implemented shows that policy makers recognize the potential impact of the Act on protecting Indigenous women.

As Savannah's Act and the Not Invisible Act are both newly signed into law, their efficacy will depend greatly on how the laws are implemented. One key determinant of successful implementation will be the involvement of Indigenous women, including survivors of violence and family members of survivors, victims, and missing women—key stakeholders in the fight for justice. The Not Invisible Act mandates the creation of an advisory committee on violent crimes. In addition to tribal leaders and law enforcement, the Act indicates the committee is to be made up of survivors and service providers who will work together to issue recommendations to the Department of Justice and Department of the Interior (The Navajo Nation, Office of the President and Vice President, 2020).

Another key to implementation is respect for Indigenous culture and tradition. Under Savannah's Act, agencies are tasked with ensuring that culturally appropriate services are available for victims of violence and trafficking, such as access to culturally-aligned mental and physical health providers. Additionally, the Act requires the "[c]ulturally appropriate identification and handling of human remains identified as belonging to American Indians" (2020). Guaranteeing that Indigenous women, survivors, families, and service providers have a say in how these two acts

are adopted on the ground is vital in making sure the efforts to protect and provide justice for Indigenous women and girls are not only effective, but sustainable and appropriate as well.

It must also be noted that for both of these laws to be effective, the VAWA 2019 reauthorization bill must expand the implementation of the SDVCJ provision. Whereas non-Indian perpetrators are "above the law" (Creppelle, 2020, p. 1) in territories where the SDVCJ is not in effect—that is, they cannot be prosecuted by tribes for crimes committed in Indian country—the provision ensures that all perpetrators of violence are appropriately held responsible for their crimes, which, most pressingly include violence against women (Creppelle, 2020). This provision will also support efforts to prevent violence against Indigenous women in the first place.

DISCUSSION

Savannah's Act and the Not Invisible Act have the potential to amplify awareness of the crisis of missing and murdered Indigenous women, while also putting into action concrete strategies to prevent violence, conduct investigations, and provide services for survivors and their families. Despite the Acts both including best practice recommendations for searching for missing Native persons on and off Tribal land (The Navajo Nation, Office of the President and Vice President, 2020), a key challenge that persists is the lack of universality in the application of SDVCJ in tribal courts. Without the ability to appropriately hold non-Indian perpetrators accountable for crimes against Indigenous women, these Acts will not be able to provide the level of justice Indigenous women deserve. Additionally, as the Department of Justice did not release crime data regarding Native peoples until 1999 (Pao, 2020), the scope of the crisis and therefore best approaches to protecting Indigenous women have not been thoroughly or justly explored.

Efforts to protect Indigenous women and ensure their ability to live with safety and dignity must not stop at the passage of these Acts. Future community-based, participatory action research should evaluate implementation of the Acts, as including Indigenous women in the guidance and maintenance of the process will be vital to the success and survival of Indigenous women. Additionally, researchers and advocates should evaluate the potential impacts of expanding the SDVCJ provision to all jurisdictions. Ongoing evaluation will also be necessary in order to secure justice, violence prevention, and ongoing support for all Indigenous women.

CONCLUSION

The lack of protections in place for Indigenous women and girls throughout history has led to endemic levels of physical and sexual violence, missing women, and generational trauma. Murder is the third leading cause of death among this population, and rates of violence towards Indigenous women are 2.5 times higher than the rate of violence towards non-Indigenous women in the United States, with estimates ranging from 46-91% of Indigenous women having experienced these forms of violence, compared with 7-51% of non-Indigenous women (The Navajo Nation, Office of the President and Vice President, 2020; Burnette & Cannon, 2014). The Indian Law Resource Center (2020) found that four out of five American Indian and Alaska Native women experience violence and more than one of every two women experience sexual violence. At the same time, there has been little focus on holding perpetrators accountable, ensuring Indigenous women their rights to safety and adequate services, or implementing best practices to effectively investigate and prevent such levels of violence.

According to a 2018 survey conducted by the Urban Indian Health Institute, of 5,712 missing Alaska Native and American Indian women and girls, only 116 were registered in the Department of Justice database (The Navajo Nation, Office of the President and Vice President, 2020). Savannah's Act specifically allocates the resources needed to efficiently collect and enter data into national databases and further prevent and investigate crimes against Indigenous women. When 97% Native women experience physical, sexual, and psychological abuse at the hands of non-Indians, compared with 35% at the hands of Indian perpetrators (Rosay, 2016), it is critical that tribal courts be able to prosecute all perpetrators of violence in order to truly protect women and girls.

Despite laws in place such as VAWA which aim to protect women from violence, specific protections for Indigenous women have fallen short. While it is too soon to tell whether the Not Invisible Act and Savannah's Act will effectively address the issues discussed in this paper, with proper implementation they offer alternatives to a lack of protections and policies that have previously allowed violence towards Indigenous women to continue at disproportionate levels. It is time for Indigenous women and girls to be free of the human rights violations they have been subject to for far too long.

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